STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Glorious Family Home Care Inc

Glorious Family Home Care Inc
201 S GARDEN DR
LYNDEN, WA 98264

RE: Glorious Family Home Care Inc License # 753663

Dear Provider:

This letter addresses Compliance Determination(s) 46088 (Completion Date 08/22/2024) and 42270 (Completion Date 06/26/2024).

The Department completed a follow-up inspection of your Adult Family Home on 08/22/2024 and found that you have corrected the violations listed in the Complaint report dated 06/26/2024. Your home is back in compliance as of 08/09/2024 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10475, WAC 388-76-10475-1, WAC 388-76-10475-2, WAC 388-76-10475-2-a, WAC 388-76-10475-2-b, WAC 388-76-10475-2-c, WAC 388-76-10475-2-d, WAC 388-76-10475-2-e, WAC 388-76-10475-3, WAC 388-76-10475-3-a, WAC 388-76-10475-3-b, WAC 388-76-10475-3-c, WAC 388-76-10475-3-c-i, WAC 388-76-10475-3-c-ii, WAC 388-76-10475-3-c-iii, WAC 388-76-10475-3-c-iv, WAC 388-76-10475-4, WAC 388-76-10430-2-d, WAC 388-76-10380-2, WAC 388-76-10375, WAC 388-76-10375-1, WAC 388-76-10375-2

The Department staff who did the on-site verification:
Jennifer Nichols, Community Complaint Investigator

If you have any questions, please contact me at (206)348-9350.

Sincerely,

This document was prepared by Residential Care Services for the Locator website.

Nicholette Flynn, Field Manager
Region 2, Unit B
Residential Care Services

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STATE OF WASHINGTON
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3906-172nd St NE, Suite #100, Arlington, WA 98223

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 06/05/2024, 06/13/2024 and 06/13/2024 of:

Glorious Family Home Care Inc
201 S GARDEN DR
LYNDEN, WA 98264

This document references the following complaint number(s): 131746

The following sample was selected for review during the unannounced on-site visit: 3 of 3 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

This document was prepared by Residential Care Services for the Locator website.

Provider (or Representative) Date

WAC 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(2) Include in each medication log the:

(a) Name of the resident;

(b) Name of all prescribed and over-the-counter medications;

(c) Dosage of the medication;

(d) Frequency which the medications are taken; and

(e) Approximate time the resident must take each medication.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

(b) If the medication was refused and the reason for the refusal; and

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

(iii) A logged call requesting written verification of the change; and

(iv) A copy of written verification of the change from the practitioner received by the home by mail, facsimile, or other electronic means, or on new original labeled container from the pharmacy.

(4) Ensure that the changed or new medication is received from the pharmacy.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure the medication log (ML) for 3 of 4 residents (former Resident 1, Resident 2, and Resident 3) was up to date, included all prescribed medications, dosage, frequency and times for each medication and documentation of changes. These failures resulted in Resident 2 not receiving an ordered medication for an unknown amount of time and placed former Resident 1, Resident 2, and Resident 3 at risk for harm and further medication errors.

This document was prepared by Residential Care Services for the Locator website.

Findings included…

Former Resident 1

Record review showed the AFH admitted former Resident 1 on [redacted]/2023 with diagnoses that included [redacted] Record review showed the AFH discharged former Resident 1 on [redacted]/2024. Review of former Resident 1's assessment, dated 12/15/2023, showed former Resident 1 required caregiver administration with medications.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Bisacodyl (a medication used to regulate bowels) 10 milligrams to be given once daily as needed for constipation. Record review of former Resident 1's ML, dated May 2024, showed directions to give one Bisacodyl 10 milligrams as needed. Former Resident 1's ML, dated May 2024, did not include documentation of the frequency their Bisacodyl was to be given.

In an interview, on 06/13/2024 at 11:40 AM, Staff A (Entity Representative) stated that they did not know why former Resident 1's ML, dated May 2024, did not include the frequency that their Bisacodyl was to be given. Staff A stated they just assumed it was once a day.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Carboxymethylcellulose Sodium (a medication used to treat dry eyes) one percent eye drop to be given one to two drops in both eyes twice daily. Record review of former Resident 1's ML, dated May 2024, did not include any documentation of former Resident 1's prescribed Carboxymethylcellulose Sodium.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they remembered giving former Resident 1 their Carboxymethylcellulose Sodium, but forgot to add it to their ML, dated May 2024.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Ketotifen (a medication used to treat itching eyes) 0.025 percent eye drop to be given two drops in both eyes twice daily. Record review of former Resident 1's ML, dated May 2024, showed Ketotifen documented without any dosage directions.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they forgot to put former Resident 1's dosage directions for their prescribed Ketotifen on their ML, dated May 2024.

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Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Lidocaine (a medication used to treat pain topically) two percent jelly to be applied to their wound with dressing changes. Record review of former Resident 1's ML, dated May 2024, showed Lidocaine documented with directions to "apply to wound after changes".

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they forgot to change former Resident 1's directions on their ML, dated May 2024, for their prescribed Lidocaine.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Lorazepam (a medication used to reduce anxiety) 0.5 milligrams to be given twice daily. Record review of former Resident 1's ML, dated May 2024, showed Lorazepam directions to give 0.5 milligrams at bedtime with AFH staff initials indicating former Resident 1 was given their Lorazepam 0.5 milligrams once daily at 8:00 PM from 05/01/2024 through [redacted]/2024.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they did give former Resident 1 their Lorazepam twice daily. Staff A stated the directions to give Lorazepam once daily to former Resident 1 was an error on the ML.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Nitroglycerin (a medication used to treat chest pain) 0.4 milligrams to be given one tablet every five minutes as needed. Record review of former Resident 1's ML, dated May 2024, showed Nitroglycerin directions to give two tablets every five minutes as needed.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated former Resident 1's ML, dated May 2024, with directions to give Nitroglycerin two tablets every five minutes as needed was an error.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Omeprazole (a medication used to treat stomach acid coming up) 20 milligrams to be given daily before breakfast. Record review of former Resident 1's ML, dated May 2024, did not include any documentation of former Resident 1's prescribed Omeprazole.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they remembered giving former Resident 1 their Omeprazole, but forgot to add it to their ML, dated May 2024.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Oxycodone (a medication used to treat pain) 2.5 milligrams to be given every four hours as needed. Record review of former Resident 1's ML, dated May 2024, showed directions to give Oxycodone 2.5 milligrams four times daily as needed.

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In an interview, on 06/13/2024 at 11:40 AM, Staff A stated former Resident 1's ML, dated May 2024, with directions to give Oxycodone 2.5 milligrams four times daily as needed was an error.
Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Quetiapine (a medication used to treat certain mental disorders) 50 milligrams to be given twice daily.

Record review of former Resident 1's ML, dated May 2024, showed directions to give Quetiapine 100 milligrams twice daily with AFH staff initials indicating former Resident 1 was given Quetiapine 100 milligrams twice daily 05/01/2024 through [redacted] 2024.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated former Resident 1 did get 50 milligrams of Quetiapine twice daily and that former Resident 1's ML, dated May 2024, with directions to give Quetiapine 100 milligrams twice daily was an error.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Senna (a medication used to help regulate bowels) 8.6 milligrams to be given twice daily. Record review of former Resident 1's ML, dated May 2024, showed directions to give Senna 8.6 milligrams once daily with AFH staff initials indicating former Resident 1 was given their Senna 8.6 milligrams once daily from 05/01/2024 through [redacted] 2024.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated former Resident 1 did get Senna 8.6 milligrams twice daily and that they forgot to update former Resident 1's ML, dated May 2024.

Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was prescribed Sodium Phosphates enema (a medication used to treat problems passing stool) 19-7 gram/188 milliliters to be given once as needed. Record review of former Resident 1's ML, dated May 2024, showed documentation of "Enema as needed" without any dosage directions.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they forgot to put former Resident 1's dosage directions for their prescribed Sodium Phosphates enema on their ML, dated May 2024.

Record review of former Resident 1's ML, dated May 2024, showed documentation of MiraLAX (a medication used to regulate bowels) 17 milligrams to be given once daily as needed and Acetaminophen (a medication used to treat pain or fever) 1000 milligrams as needed. Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was not prescribed MiraLAX or Acetaminophen.

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In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they forgot to update and take the MiraLAX and Acetaminophen off former Resident 1's ML, dated May 2024.

Record review of former Resident 1's ML, dated May 2024, showed documentation of Mirtazapine (a medication used to treat depression) 30 milligrams to be given once daily at bedtime with AFH staff initials indicating former Resident 1 was given Mirtazapine 30 milligrams daily at 8:00 PM 05/01/2024 through [redacted]2024. Record review of former Resident 1's Hospice visit notes, dated 05/08/2024, showed former Resident 1 was not prescribed Mirtazapine.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they did not remember whether former Resident 1 was given Mirtazapine 30 milligrams once daily at bedtime.

Resident 2

Record review showed the AFH admitted Resident 2 on [redacted] 2009 with multiple diagnoses that included [redacted]. Review of Resident 2's assessment, dated 03/15/2024, showed Resident 2 required caregiver administration with medications.

Record review of Resident 2's current physician orders from their health care provider (HCP), dated 06/05/2024, showed Resident 2 was prescribed Melatonin (a supplement used to aid sleep) 10 milligrams to be given once daily at bedtime. Record review of Resident 2's medication log (ML), dated June 2024, showed there was caregiver initials documented indicating Resident 2 received their Melatonin 06/01/2024 through 06/04/2024.

Observation, on 06/13/2024 at 12:08 PM, showed Resident 2's pharmacy packaged multi-dose medication supply for 8:00 AM and 8:00 PM medications did not include Melatonin. The AFH's medication supply did not include Melatonin for Resident 2.

In an interview, on 06/13/2024 at 12:08 PM, Staff A (Entity Representative) stated they had no orders from Resident 2's HCP to discontinue their Melatonin and had no Melatonin at the AFH for Resident 2. Staff A stated that they did not notice that Resident 2's Melatonin was not in their multi dose pack, so they thought they were administering it to Resident 2. Staff A stated they did not know how many days Resident 2 did not get their prescribed Melatonin.

Record review of Resident 2's Current physician orders from their HCP, dated 06/05/2024, showed Resident 2 was prescribed Sennosides-Docusate Sodium (a medication used to help regulate bowels) 17.2-100 milligrams to be given twice daily as needed. Record review of Resident 2's ML, dated June 2024, did not include any documentation of Resident 2's prescribed Sennosides-Docusate Sodium.

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In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they forgot to update and add Resident 2's Sennosides-Docusate Sodium to their ML, dated June 2024.
Record review of Resident 2's current physician orders from their HCP, dated 06/05/2024, showed Resident 2 was prescribed Vitamin D-3 (a supplement that aids the body to absorb other vitamins) 2000 units to be given daily. Record review of Resident 2's ML, dated June 2024, showed directions to give Vitamin D-3 4000 units daily with AFH staff initials indicating Resident 2 was getting Vitamin D-3 4000 units daily 06/01/2024 through 06/04/2024.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated Resident 2 was given Vitamin D-3 2000 units once daily and not 4000 units once daily. Staff A stated that Resident 2's ML, dated June 2024, with directions to give Vitamin D-3 4000 units instead of the prescribed 2000 units was an error.

Record review of Resident 2's current physician orders from their HCP, dated 06/05/2024, showed Resident 2 was prescribed Lamictal (a medication used to prevent involuntary muscle tone abnormalities and movements) 25 milligrams to be given once daily. Record review of Resident 2's ML, dated June 2024, showed directions to give Lamictal 25 milligrams four times daily.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated Resident 2 was given Lamictal 25 milligrams once daily as prescribed. Staff A stated the directions on Resident 2's ML, dated June 2024, that say to give Lamictal 25 milligrams four times daily was an error.

Record review of Resident 2's current physician orders from their HCP, dated 06/05/2024, showed Resident 2 was prescribed Hydrochlorothiazide (a medication used to lower blood pressure) 25 milligrams to be given once daily. Record review of Resident 2's ML, dated June 2024, showed directions to give Hydrochlorothiazide 25 milligrams four times daily.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated Resident 2 was given Hydrochlorothiazide 25 milligrams once daily as prescribed. Staff A stated the directions on Resident 2's ML, dated June 2024, that say to give Hydrochlorothiazide 25 milligrams four times daily was an error.

Resident 3

Record review of Resident 3's current physician orders from their HCP, dated 06/05/2024, showed Resident 3 was prescribed Senna 8.6 milligrams to be given one tablet, one to two times daily. Record review of Resident 3's ML, dated June 2024, showed directions to give two tablets of Senna 8.6 milligrams once daily with AFH staff initials indicating Resident 3 was given two tablets of Senna 8.6 milligrams once daily.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated Resident 3 was given Senna 8.6

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milligrams one tablet twice daily as prescribed. Staff A stated the directions on Resident 3's ML, dated June 2024 that said to give Senna 8.6 milligrams two tablets once daily was an error.

Record review of Resident 3's current physician orders from their HCP, dated 06/05/2024, showed Resident 3 was prescribed Cetirizine (a medication used to treat allergies) 10 milligrams to be given once daily as needed. Record review of Resident 3's ML, dated June 2024, showed directions to give Cetirizine 10 milligrams once daily.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated the directions for Resident 3's Cetirizine 10 milligrams to be given once daily routinely on Resident 3's ML, dated June 2024, was an error. Staff A stated they forgot to update and change Resident 3's ML, dated June 2024.

Record review of Resident 3's current physician orders from their HCP, dated 06/05/2024, showed Resident 3 was prescribed Acetaminophen 500 milligrams to be given one tablet as needed. Record review of Resident 3's ML, dated June 2024, showed directions to give Acetaminophen 325 milligrams to be given two tablets every six hours as needed.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated the directions for Resident 3's Acetaminophen 325 milligrams to be given two tablets every six hours as needed on Resident 3's ML, dated June 2024, was an error. Staff A stated they forgot to update and change Resident 3's ML, dated June 2024.

Record review of Resident 3's current physician orders from their HCP, dated 06/05/2024, showed Resident 3 was prescribed Polyethylene Glycol (a medication used to help regulate bowels) 17 grams to be given once daily as needed. Record review of Resident 3's ML, dated June 2024, showed directions to give Polyethylene Glycol 17 grams every three days as needed.

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated the directions for Resident 3's Polyethylene Glycol 17 grams to be given every three days as needed on Resident 3's ML, dated June 2024, was an error. Staff A stated they forgot to update and change Resident 3' s ML, dated June 2024.

Record review of Resident 3's current physician orders from their HCP, dated 06/05/2024, showed the following physician ordered medications were not documented on Resident 3's June 2024 ML:
- Triamcinolone Acetonide (a medication used to reduce swelling and itching of skin) 0.1 percent cream to be applied twice daily
- Centrum Silver (a vitamin used to supplement body nutrients) to be given once daily
- Ascorbic Acid (a vitamin used to supplement body nutrients) 1000 milligrams to be given once daily
- Cholecalciferol (a vitamin used to supplement body nutrients) 2000 units to be given once daily

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- Sertraline (a medication used to treat depression) 50 milligrams to be given once daily
- Vitamin E (a vitamin used to supplement body nutrients) 400 units to be given once daily
- Lovastatin (a medication used to lower levels of a waxy substance in the blood stream) 40 milligrams to be given once daily
- Losartan (a medication used to reduce blood pressure) 50 milligrams to be given twice daily
- Amlodipine (a medication used to reduce blood pressure) five milligrams to be given once daily
- Pantoprazole (a medication used to reduce stomach acid) 40 milligrams to be given twice daily

In an interview, on 06/13/2024 at 11:40 AM, Staff A stated they thought Resident 3's Triamcinolone, Centrum Silver, Ascorbic Acid, Cholecalciferol, Sertraline, Vitamin E, Lovastatin, Losartan, Amlodipine and Pantoprazole were all discontinued, so they did not document them on Resident 3's ML, date June 2024. Staff A stated they did not have an order from Resident 3's HCP to discontinue Resident 3's Triamcinolone, Centrum Silver, Ascorbic Acid, Cholecalciferol, Sertraline, Vitamin E, Lovastatin, Losartan, Amlodipine and Pantoprazole.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Glorious Family Home Care Inc is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Provider (or Representative) Date

WAC 388-76-10430 Medication system.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to administer medications as required for 1 of 4 residents (Resident 2). This failure resulted in Resident 2 not receiving all prescribed medications and placed them at risk for medical complications and increased sleeplessness.

Findings included…

This document was prepared by Residential Care Services for the Locator website.

Record review showed the AFH admitted Resident 2 on [redacted] 2009 with multiple diagnoses that included [redacted]. Review of Resident 2's assessment, dated 03/15/2024, showed Resident 2 required caregiver administration of medications.

Review of Resident 2's current physician orders from their health care provider (HCP), dated 06/05/2023, showed an order for Melatonin (a supplement used to aid sleep) 10 milligrams to be administered to Resident 2 once daily at bedtime.

Record review of Resident 2's medication log (ML), dated June 2024, showed documentation of caregiver initials indicating Resident 2 received their Melatonin 06/01/2024 through 06/04/2024.

Observation, on 06/13/2024 at 12:08 PM, showed Resident 2's pharmacy packaged multi-dose medication supply for 8:00 AM and 8:00 PM medications did not include Melatonin. The AFH's medication supply did not include Melatonin for Resident 2.

In an interview, on 06/13/2024 at 12:08 PM, Staff A (Entity Representative) stated they had no orders from Resident 2's HCP to discontinue their Melatonin. Staff A stated the AFH did not have Melatonin at the AFH for Resident 2. Staff A stated that they did not notice that Resident 2's Melatonin was not in their multi dose pack, so they thought they were administering it to Resident 2.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Glorious Family Home Care Inc is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Provider (or Representative) Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

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Based on interview and record review, the Adult Family Home (AFH) failed to ensure that 1 of 3 current resident's (Resident 4) Negotiated Care Plan (NCP) was revised to address their skin care needs. This failure placed Resident 4 at risk for unrecognized and unmet care needs.

Findings included…

Record review showed the AFH admitted Resident 4 on [redacted] 2023 with diagnoses that included [redacted] and [redacted].

Review of Resident 4's Hospice care notes, dated 05/29/2024, showed that Resident 4 had wounds to the inner aspects of both knees. Resident 4's Hospice care notes, dated 05/29/2024, showed Resident 4 required wound care, wound dressing changes twice a week, and as needed when the dressing was saturated.

Review of Resident 4's NCP, dated 08/29/2023, showed no documentation that Resident 4 had wounds or how their wound care needs were addressed.

In an interview, on 06/05/2024 at 10:50 AM, Staff A (Entity Representative) stated that Resident 4 developed wounds to their inner knees "about a month or so ago". Staff A stated that they did not yet revise Resident 4's NCP to address their wound care needs.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Glorious Family Home Care Inc is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Provider (or Representative) Date

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

(1) Resident; and

(2) Adult family home.

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This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure that 1 of 4 resident's (former Resident 1) Negotiated Care Plan (NCP) was agreed to and signed and dated by the resident and AFH. This failure placed former Resident 1 at risk for unrecognized and unmet care needs.

Findings included…

Record review showed the AFH admitted former Resident 1 on [redacted] 2023 with diagnoses that included [redacted] and [redacted]

Review of former Resident 1's NCP, dated 10/06/2023, showed there was no signatures from former Resident 1 or their representative, and the AFH indicating it was agreed to.

In an interview, on 06/05/2024 at 10:50 AM, Staff A (Entity Representative) stated that they did not know why there was no signatures of former Resident 1 or their representative, and the AFH on former Resident 1's NCP indicating it was agreed to.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Glorious Family Home Care Inc is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

_____ _____

Provider (or Representative) Date

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