Home License /Criminal Background/ Resident quality of life issues

The provider failed to ensure five years had passed before allowing a volunteer caregiver who disclosed a conviction for forgery in 2005 to have unsupervised access to residents. This failure resulted in three residents being cared for by an unqualified person.

The provider gave false information to the department during an investigation.

The provider's allowed two staff and to assume responsibility for the adult family homes operations and management without following the prescribed process for change of ownership for over three years. This failure resulted in six residents and their families not properly informed of the identity of the licensees while two staff assumed charge of the home's day to day operation and management without an adult family home license under their names without the approval of the department.

The provider failed to understand her inability to meet her business financial obligations which could result in the sudden eviction of the vulnerable residents living in her adult family home.

In addition the provider did not inform the residents or their representative that the citation was pending which would require emergent relocation of the resident. This failure of practice placed the residents at immediate risk of suddenly being without a home and experience unsafe and disorderly discharge.

The provider failed to submit a change of ownership application when there is a change in the business structure of the adult family home. This failure resulted in the business being listed in department records as a sole proprietorship after it was incorporated.
REPEAT DEFECIENCY

The provider failed to ensure and years and see evacuation drills occurred at least every two months

The provider failed to ensure emergency evacuation drills occurred at least every two months.
REPEAT DEFECIENCY

The licensee allowed one caregiver to work unsupervised with four vulnerable adults without first receiving successful criminal background results.
REPEAT DEFECIENCY REPEAT DEFECIENCY

The licensee failed to ensure three residents were not exposed to a facility dog after the dog bit a resident and urinated in defecating in the home including on a resident's bed. This failure resulted in harm for one resident who was bitten by the dog and placed the residents at risk for additional dog bites. In addition this failure resulted in the residents having to live in unsanitary conditions.

The licensee failed to ensure two residents had their care plans updated when their conditions changed or incidents occurred requiring an update for care and services. This failure placed the residents at risk for unmet needs.

The licensee failed to ensure two residents received appropriate care and services in a manner that actively supported and improved their quality of life. The licensee's delivery of inappropriate care and services related to the residents' diagnoses resulted in harm for one resident who suffered mental anguish and a sudden involuntary discharge and harm for another resident, who sustained a dog bite and did not have her mental health issues appropriately addressed.

The licensee failed to ensure one resident received an appropriate discharge from the adult family home. This failure resulted in a sudden, disorderly discharge.

The adult family home failed to report one staff to the department's toll free complaint line when an allegation of sexual abuse of a minor was made against him. This failure placed six residents at risk of being exposed to an individual whose criminal background was unclear.

The licensee failed to ensure a criminal history background inquiry was submitted and results received every two years for one caregiver. This failure placed three vulnerable residents at risk for harm if the caregiver had undisclosed infractions since her last background inquiry was obtained.

Repeat deficiency

The adult family home failed to ensure two caregivers spoke English well enough to respond appropriately in an emergency situation. This failure placed five residents at risk of not receiving help in the event they required emergency services.

Repeat deficiency

Repeat deficiency

The provider failed to understand how the pattern of inadequate assessments, care planning and implementation of care plans led to neglect of vulnerable adults. The provider failed to provide the care to keep residents with histories of elopement and exit seeking behaviors safe and continued to admit residents with dementia and exit seeking and wandering behavior. The provider failed to fully and timely implement conditions placed on the license. Residents continued to leave the home undetected.

The adult family home failed to ensure one resident received necessary care and services from an individual qualified to do so. These failures contributed to development of infections of the pressure sores requiring surgical intervention from exacerbation of bed sores and lethargy related to dehydration and medical problems.

The provider demonstrated that she lacked the understanding to care for special needs of vulnerable adults with developmental disability, mental illness and acting out behavior by not developing plans or implementing skills to deescalate agitation behavior. The provider was required to have additional special training in 2009 for behavior management but continues to have the same problems. In addition, the provider does not have a functional system in the home to document and track behavior or ensure that residents receive medications as prescribed. This resulted in residents not receiving necessary care and services.

The provider's behavior delayed or failed to meet five of nine department conditions imposed on February 4, 2011 including the requirement to immediately contact the Division of Developmental Disabilities for specific behavior training and assistance with one resident and the requirement to develop safe medication systems in the home.

The provider demonstrated a lack of understanding and judgment when decisions were made to:

(1) leave a resident unsupervised at an appointment although the assessment clearly stated the resident needed constant supervision
(2) Leave a resident unsupervised with a caregiver whose background had not been checked
(3) Move a resident into the home without having assessment and care plan information available.

Further, the provider did not ensure a resident's appointments for medical issues were kept.

The adult family home failed to ensure one caregiver. This failure placed five residents at risk of being cared for by unqualified staff.

Repeat deficiency

The adult family home failed to notify the department when a state funded resident experienced a change of condition and was moved from the providers boarding home and the adult family home. This failure placed the resident at risk for not receiving necessary care and services and created confusion about the whereabouts of the resident.

The adult family home failed to keep and maintain a record on one resident who had recently moved into the home. This failure created uncertainty regarding what services to provide, when to provide them and how they are to be delivered to the resident.

The adult family home failed to ensure one resident had an assessment completed before admission to the adult family home. This failure placed the resident at risk for harm or injury if staff was unfamiliar with any significant history how to effectively care for him.

The provider demonstrated that she lacked the ability to provide care to vulnerable adults. The provider has been unable to or unwilling to follow minimum licensing requirements required of licensed adult family home providers. Continued failure to meet the minimum licensing requirements puts four residents and potential future residents at risk of receiving substandard care.

Repeat deficiency

Repeat deficiency

The provider failed to be in the home daily and failed to provide day-to-day oversight as required in the conditions until he had a fully qualified resident manager.

The provider failed to ensure two residents had the chance to exercise their right to engage in meals and social activities in the home by housing the non-ambulatory residents on the lower level of a split level home; the only common area was small room only large enough for a table, two chairs, and a bookshelf. Having no access to the upper level of the home this isolated the residents and potentially diminished resident quality of life.

REPEAT DEFIENCY

The provider failed to ensure she had liability insurance for the home.

The adult family home failed to allow a local building inspector in to approve the newly created bedroom on the lower level of the home. This failure made it unclear whether the building codes were met during the construction and the home was safe.

The adult family home utilized five licensed bedrooms for non-resident individuals. This failure resulted in the home not having available beds for residents.

The licensee failed to ensure one resident received care and services in a manner that actively supported the resident safely and quality of life with the resident when he did not receive care and services to address his physical needs. This failure placed the resident at risk for harm related to unmet care needs and caused him harm when he was transferred without an assessment regarding how to transfer the resident and he sustained a broken shoulder.
REPEAT DEFIENCY

The provider failed to ensure three residents had admission agreements renewed every 24 months. This placed these residents at risk of not knowing current expectations of the adult family home.

The provider failed to have a written authorization from the resident's representative to manage the resident's money, failed to keep an accurate and complete accounting, and failed to provide the financial record when requested for one resident. This placed the resident at risk of financial exploitation.

To the provider failed to protect one resident's right to privacy by allowing an auditory monitor to be placed in her bedroom. The resident was not able to remove the monitor. This placed the resident at risk of loss of privacy.

The provider failed to promote care to enhance dignity and respect for two residents by arguing and failing to recognize and respect the importance of making personal choices.

The licensee who is the sole owner of the adult family home was responsible for provision of care for two vulnerable adults in another home without a license from January 16, 2010 through May 11, 2010.

The licensee operated an unlicensed adult family home in Kent, Washington.
The adult family home failed to ensure the home was not over capacity when a former resident spent over 5 hours at a time, four days a week in the home receiving care. This failure placed all residents at risk of not receiving care.
REPEAT DEFIENCY

The adult family home failed to ensure that one resident had a crisis plan. This failure placed the resident at risk of harm and injury.
REPEAT DEFIENCY

He
The adult Family Home Failed To Ensure that one resident had a crisis plan. This failure placed the residents at risk of harm and injury.
Repeat deficiency

The adult family home failed to ensure services and care plans were reviewed with three residents every two years as required. These failures violated the resident rights.
REPEAT DEFIENCY
REPEAT DEFIENCY

Of the adult family home failed to ensure there was enough staff available in the home to meet the needs of each resident. In addition, the adult family home failed to ensure all staff was skilled to provide the care as identified in the assessments. This failure placed all residents at risk of receiving inappropriate care.
REPEAT DEFIENCY

The provider failed to ensure one staff had specialty training in the areas of developmental disabilities and mental health.

The home failed to ensure the staff had plans to follow for safety and behavior problems, medication management or care for three residents with special care needs. The care plans did not address one resident's threatening and disruptive behaviors or in other residents complex diabetic medical issues. Failure to ensure the care plans were developed and followed placed all residents at risk for physical and emotional harm and a decline in health for two residents.

The home failed to monitor and manage one resident's disruption and threatening behavior with inappropriate and consistent measures to minimize aggression and failed to monitor and supervise another resident. Failure to monitor, manage and help the residents reach their highest level a physical, mental and psychosocial well being placed five residents at risk for harm from one resident's behaviors and placed another resident at risk of harm from declines in his health.

The provider failed to keep staff documents in a place readily accessible to the Department. The provider failed to ensure the negotiated care plan for residents addressed their needs.
REPEAT DEFIENCY

The entity representation failed to demonstrate he understood the importance of supervising and monitoring the ongoing progress and competence of the newly hired resident manager. This failure resulted in the resident manager not having a thorough understanding of effective interventions to use with one resident who exhibited physically and verbally assaultive behaviors. This then resulted in a violation of the resident's right to be treated in a dignified manner and decrease in the resident's mental well being.

In addition, the entity representation failure resulted in a continued non compliance with the Department regulations when he did not ensure the resident manager understood when and how to update the negotiated care plan for three residents and complete negotiated care plans for five residents and the home's incident log for two incidents involving one resident.
REPEAT DEFIENCY

The Entity Representative failed to ensure r the negotiated care plan was signed by the resident or resident representative when it was reviewed and revised, putting five residents at risk for unmet care needs.
Repeat deficiency

The home, through the Entity Representative, failed to ensure the Negotiated care Plan for one resident was updated when a significant change assessment was done, when parts of the plan no longer addressed resident care needs, and at least every twelve months. This failure put one resident at risk for unmet care needs.

The adult family home failed to promote care in a manner that maintained and enhanced resident dignity and respect for one resident who exhibited active physically and verbally

assaultive behaviors this failure resulted in the resident manager's use of interventions which increased the resident's negative behaviors and decreased the resident's mental well being.

The provider failed to ensure the person he left in charge of the home while he was out of the country for an undetermined amount of time, was fully oriented to the home and knowledgeable about resident care needs. The provider failed to understand the importance of ensuring the home was in compliance with regulations and failed to ensure the caregiver left in charge was qualified to administer medications and familiar with residents' needs, when he left the country. These failures placed residents at risk for harm.

The adult family home failed to obtain a criminal history background check on one staff prior to allowing unsupervised access to three vulnerable adults when the provider was out of the United States from August 13, 2011 until September 1, 2011.

The providers demonstrated that they did not have the understanding or ability to meet the psychosocial, personal, and special care needs of vulnerable adults. This resulted in violation of resident's rights and inadequate care for two vulnerable residents.

The providers failed to provide appropriate dementia care and services when they admitted and retained an actively exit seeking resident, using door locks and special devices to contain the resident. The providers were unable to adequately supervise or manage the resident.

The licensee failed to have policies and procedures in place for staff to implement immediate contact of local emergency services for residents

The provider allowed two caregivers to have unsupervised access to residents before receiving background check results.

The provider failed to ensure each caregiver had basic communications skills to be able to communicate with the resident in her primary language, respond to emergencies, and to read and implement the resident negotiated care plan.

The provider had been unable or unwilling to follow minimum licensing requirements required of the licensed adult family home providers.

The Co-providers failed to ensure food safety training was completed in calendar year 2010 by three caregivers. Additionally, one staff did not complete any continuing education hours for

calendar year 2010. These failures placed the residents at risk for care received from unqualified staff.

Repeat deficiency

REPEAT DEFECIENCY

REPEAT DEFECIENCY

The home failed to keep one resident record and one staff record in the home. This failure caused a delay in reviewing necessary information by authorized department personnel during an on-site investigation and also caused the potential for unauthorized individuals to have access to one resident's record when not secured by the home.

The licensee failed to ensure staff background checks on file we-re valid. This is an uncorrected violation from February 23, 2011.

REPEAT DEFECIENCY

The provider did not have the understanding to ensure a system was in place to meet the residents' needs in the home and prevent violations of the Washington administrative code. This failure placed all residents at risk for not receiving the necessary care and services.

The home failed to ensure two residents, case managers and nurse delegators were notified after both residents sustained physical injuries. The home also failed to notify the nurse delegator when one former resident was moved to another home. This failure prevented the case manager and nurse delegator from knowing the current status of all three residents.

REPEAT DEFECIENCY

The home failed to ensure one resident's assessment was available for licensor review. This failure prevented the licensor from obtaining information regarding the current status of the resident.

Repeat deficiency

The home failed to provide a plan of correction within 10 working days for a follow up inspection with statement of deficiencies. This failure placed four residents at risk for the late in providing and implementing corrections to the deficiencies.

Repeat deficiency

The home failed to ensure the provider comply with the conditions imposed on the home's license. This failure placed four residents at risk for not having the required staff and care supervision from the provider needed in operating the home.

Repeat deficiency

Repeat deficiency

Repeat deficiency

The licensee lacks the understanding and ability to operate an adult family home and meet the needs of vulnerable residents as evidenced by her inability to comply with regulations. The licensee failed to ensure medications were locked, failed to assess the need for Medical Devices, failed to ensure egress doors were unblocked, failed to ensure the smoke detectors functioned, staff members lacked continuing education qualifications, failed to have CPR and first-aid training certification, failed to have dementia and mental health specialty training, failed to have current background check results for staff, the home lacked liability insurance, did not provide a plan of correction for statement of deficiencies, did not comply with conditions on the home's license, failed to have a resident assessments, failed to have preliminary care plans, failed to have a negotiated care plan.

The provider failed to demonstrate understanding of the requirement to remain in compliance with the adult family home licensing regulations and failed to demonstrate the ability to meet personal and business financial obligations. Additionally, the provider failed to participate in the regular oversight of the home. These failures placed two residents at risk for not having their care needs met.

The provider knowingly allowed a convicted felon to live in the home and have unsupervised access to vulnerable adults, engaged in the illegal use of drugs and illegal activity, made false statements to the department complaint investigator and knowingly permitted and abetted illegal activity in the adult family home. These failures jeopardized the safety of two vulnerable adults and caused the vulnerable adults to become victims of abuse and exploitation. In addition, these failures caused a potential for unmet care needs for one resident being cared for by a person under the influence of drugs and being left alone or with unqualified staff.

The adult family home failed to ensure a firearm was kept secured and locked in the home. This failure placed one resident and another vulnerable adult at risk for harm

and injury from potential accidents from unauthorized use of the firearm and /or from use by someone who might be under the influence of alcohol and /or drugs.

The licensee did not ensure the number of persons who receive personal care in the home including residents and children do not exceed the licensed capacity of the home. This failure placed residents at risk for not having their needs met.
Repeat deficiency

The entity representative demonstrated a lack of understanding of her duty to provide the oversight necessary to ensure each resident received care and services in accordance with their assessment and negotiated care plan. Failure to monitor the home and staff resulted in harm for one resident who developed multiple pressure sores and required hospitalization and harm for a another resident who sustained an injury requiring emergency treatment.

The provider admitted a resident whose needs were greater in the home could provide. This failure placed one resident at risk of unmet health needs and a diminished quality of life.

The provider failed to develop a plan to reduce confusion, agitation, and behavior problems for two residents. This placed the residents at risk for exhibiting increased problem behaviors.

The licensee did not request a reassessment when a resident's behaviors became so challenging for staff that the provider tried to place him in an unlicensed room in the home's basement. In addition the provider did not request a reassessment after the resident eloped from the home.

The licensee did not update the care plan for one resident regarding a change in the resident's behaviors including his elopement from the home. This failure placed one resident at continued risk for elopement.

The licensee failed to ensure criminal background inquiries were current for the provider and co-provider. Further, there was no criminal background inquiry for an adult son who resided in the home. This failure placed two residents at risk of harm from persons with possible disqualifying background checks.
Repeat deficiency

The provider failed to ensure a caregiver was in the home with residents who were not assessed as safe to be in the home alone.

The provider demonstrated a lack of understanding necessary to safely care for vulnerable adults. This placed two vulnerable adults at risk for injury and death.

The provider failed to develop a plan to safely care for and supervise one resident and he failed to involve appropriate professionals for two residents.

Repeat deficiency

The entity representative failed to ensure he had a qualified caregiver present in the home to supervise and care for one resident while caregivers were gone from the home. This failure resulted in an the resident being left home alone without a caregiver present to provide needed assistance and placed him at risk for unmet care needs and harm.

The licensee failed to ensure that either the resident manager lived in the home or that the care staff that stayed at the home during the night was qualified and the home had 24 hour staffing. Failure of the licensee placed the resident at risk of inappropriate care.