Safety and Environment

All citations and comments were retrieved from The Adult Family Home Advanced Search Results at www.dshs.wa.gov

These are taken only from licensed homes which are licensed to care for people with developmental disabilities.

This is only a small portion of the citations, fines and enforcement letters over the past 20 months.

*"**About enforcement letters:** This search only captures enforcement letters regarding actions taken on or after April 15, 2010. To learn if the home has enforcement actions taken prior to April 15, 2010, please contact the RCS office where the home is located."*

The provider failed to ensure the ramps outside the home were safe for the five residents that lived in the home.

The provider failed to ensure the home was kept clean and in good repair and that toxic substances were not accessible to the resident's.

The provider failed to ensure Medical Devices such as seat belts and side rails were addressed for safety care plans and developed and informed consent signed.

The provider failed to ensure the two residents receive safe and adequate assistance for mobility and toileting.

The provider failed to ensure Renton resident was protected from neglect.

One resident suffered neglect as a result of staff disallowing the resident opportunity to call for assistance during the night by disabling her call bell system and also by chastising the resident when she was able to call for assistance during the time that the call bell was working and causing her not to call for help even when she had the call bell.

The provider failed to follow the condition on the license of the adult family home to notify and and involve the registered nurse consultant when one resident had a broken shoulder and a fall with a head injury. This prevented the registered nurse from training the provider and staff how to meet the resident's care needs and updating the plan of care to meet the residents' needs.

The provider failed to meet his obligations of being in compliance with his home's well and septic system.

The facility failed to notify the department complaint resolution unit when a resident was missing from the adult family home.

The licensee failed to provide care and services that promoted individual needs and quality of life for one resident when the provider complained to the resident about helping the resident at night with incontinent care and made her wait up to 30 minutes to receive incontinent care.

The facility failed to comply with the limits placed on the adult family home license.

The facility failed to ensure resident safety when the facility and staff did not follow the residents care plan on monitoring the resident and how to respond when a resident went missing from the home.

The licensee failed to provide care and services in a manner that provide safe care and dignity for a resident who had a history of frequent falls.

The provider failed to ensure enough staff was on duty to meet the care needs of five residents who resided in the home. The need for frequent one on one supervision for one resident, as well as the need to provide care and services to the other vulnerable adults resulted in a diminished quality of life for one resident and place the other residents at risk for unmet care needs.

The adult family home failed to ensure the total number of residents living in the home did not exceed the number of beds licensed on record with the department for the adult family home.

The adult family home failed to ensure a caregiver was present in the home to meet the needs of three residents. This failure placed three residents at risk for unmet needs.

The provider lacked understanding and ability to meet the psychosocial, personal and special care needs of vulnerable adults.

The adult family home failed to have enough staff available to meet one resident's nighttime care needs. This failure resulted in one resident receiving undignified care and not being toileted at night.

The adult family home failed to provide nighttime toileting to one resident. The provider's failure to meet the resident's assessed needs and preferences constituted a pattern of conduct that resulted in the neglect to one resident. The provider placed the resident at risk of harm from skin breakdown, urinary tract infections and mental and emotional distress from being incontinent. In addition the failure resulted in the resident being disrespected and receiving care that was not dignified.

The licensee failed to ensure there was a current crisis plan for one resident with a history of assault and non-compliant behaviors. This failure placed the resident at risk of not receiving appropriate care and placed other residents at risk of injury.

The adult family home failed to ensure one resident who smoked received necessary care and supervision to ensure his safety and the safety of other residents in the home. These failures placed the residents at risk of injury.

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 other 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 sudden, disorderly discharge.

The Co-providers failed to ensure negotiated care plans included safety plans for residents who smoked, medication management for one resident, who was periodically away from the home, and safe use of a bed rail. These failures

placed the residents at risk for their need for safe care and services not being met as well as risk for harm.

The Co-providers failed to ensure safe care and services were provided for two residents who smoked in the home. These failures placed the resident at high risk for injury from burns.
The Co-providers failed to ensure a resident was assessed as needed bed rails. Co-providers did not identify how and when the way a rail was used and how the resident was monitored for safety. This placed the resident at risk for entrapment.

The adult family home failed to ensure one resident who smoked received necessary care and supervision to ensure his safety and the safety of the other residents in their home these failures placed the residents at risk of in injury.

The adult family home failed to ensure two staff who witnessed resident to resident altercations with physical abuse notified the department's complaint resolution unit 1-800 number. In addition, the family home failed to immediately notify the Department case managers, medical professionals, and the representatives of the resident. This failure placed the resident at risk of further abuse.

The adult family home failed to notify appropriate professionals involved in one resident's care when there was an altercation between two residents that resulted in injury. This failure contributed to an unsafe environment for the residents.

The adult family home failed to provide adequate supervision to meet the needs of three residents who had diagnoses of dementia and were assessed with exit seeking behaviors. This failure placed the residents at risk for unmet needs and environmental injury.

Repeat deficiency

Repeat deficiency

The provider failed to provide supervision for three residents.

The adult family home neglected vulnerable adults when they failed to provide a safe environment and supervise residents at all times while continuing to admit residents with exit seeking and wandering behaviors. This failure placed the residents at risk of harm because they continued to exit the home unnoticed.

The adult family home failed to notify the department when one resident went missing from the home. This failure placed one resident at risk for non-treatment had she been harmed while she was missing from the home.

Repeat deficiency

The adult family home failed to ensure one resident with exit seeking and or wandering behaviors was re-evaluated and adequately supervised. The adult family home failed to ensure one resident was seen by a medical professional in a timely manner after a fall resulted in a head injury.

Repeat deficiency Repeat deficiency Repeat deficiency

The provider failed to ensure that one resident's negotiated care plan included direction regarding how to reduce tension, agitation and problem behaviors and included a plan to follow in case of a foreseeable crisis related to the resident's assessed needs. This may have escalated agitation behavior necessitating transport to the hospital.

Repeat deficiency

The provider failed to keep a log of incidents affecting resident welfare for one resident in order to keep track of problems and identify patterns of behavior or

agitation. This resulted in an inability of staff to track and report agitation incidents.

Repeat deficiency Repeat deficiency

The provider failed to ensure one resident received the care needed to prevent falls and pressure sores while living in the home. This caused harm and a decreased quality of life for the resident.

It was discovered physical restraints had been used without indications to treat medical symptoms and without supervision of a licensed medical person for one resident living in the home. This did not meet the regulations and placed the resident at risk of potential harm including serious injury secondary to the use of physical restraints.

The provider failed to ensure safe and appropriate access from the room by blocking the door for one resident when her bedroom door was blocked from the outside with a coat hanger. This failure placed the vulnerable adult at potential risk of harm related to not being able to exit the room especially of extreme concern if there was an emergency.

The provider failed to ensure video equipment was not used for one resident living in the home. This did not meet the regulations and placed the vulnerable adult at potential risk of privacy violation and decreased quality of life.

The adult family home failed to provide adequate staffing for one resident who required supervision outside the adult family home. This failure placed the resident at risk for environmental harm.

The provider failed to ensure the main lower level exit, the garage, used by the residents in the basement, was not subject to being locked or blocked. The only other exit from downstairs had a high threshold, uneven cobblestone and a blocked pathway. This placed the wheelchair bound resident who lived downstairs at risk of entrapment in the event of a disaster or fire.

Repeat deficiency

The provider failed to ensure one resident had means to call for help. The resident's bedroom was on the lower level of the house and the providers bedroom was on the upper floor. The resident was too confused to call for help. This placed the resident at risk of needing help and not being able to call for help.

The provider failed to ensure the hot water temperature was less than 120° F in one bedroom and the kitchen sinks.

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.

The provider failed to develop a negotiated care plan for one resident to address night wandering behavior and sleep disturbance. This resulted in an inadequate response to the resident's care needs.

Repeat deficiency

Repeat deficiency

The provider failed to ensure two residents were not isolated in their basement bedroom without means to get upstairs and less they were to go outside in a

wheelchair by staff on an outside ramp. This caused isolation and created a safety risk.

The provider failed to ensure five residents had means of communication such as call bell or phone to call for help from their bedrooms. This placed five residents at risk of being injured in an event of an emergency and not being able to call for help.

The providers failed to ensure that bedroom doors opened from the inside as there were push button locks on the three bedroom doors leading to the common hall. The provider failed to ensure that the front door opened without special knowledge or effort.

The provider failed to ensure one resident had safety assessment for the use of the side rail, that the side rail was included in the negotiated care plan and bad enough information about the risks of using a side rail was given to make an informed decision. This placed one resident at risk for harm and or entrapment.

The Co-providers failed to ensure two residents were assessed as needing bed rails, were informed of the safety of risks, and care planning documented for use of the device. These failures placed the residents at risk for serious injury or death from entrapment in devices they may not have needed.

The Co-providers failed to ensure one resident who was unable to get out of her room independently, was regularly brought out of her bedroom into the presence of others in the home. This failure cause a violation of the resident's right to be free of involuntary seclusion in her room and may have contributed to an acceleration of her cognitive decline.

The Co-providers failed to ensure windows were screened in bedrooms occupied by three residents. This failure placed the three residents living in the rooms at risk for discomfort due to bites from flying insects and other vermin entering their rooms.

The Co-providers failed to ensure a call bell system was available to four residents who were able to use such a device. This failure placed the residents at risk for care needs not being met at night or other times when staff was not physically present in the adult family home area of the residents.

The Co-providers failed to ensure interior and exterior portions of the home were kept in a safe, sanitary, comfortable, and homelike condition and placed the five residents at risk for diminished quality of life and possible injury.

Repeat deficiency

The Co-providers failed to have a system in place to ensure the water temperature in the lower level kitchen sink did not exceed 120° F and placed four ambulatory residents at risk for injury from scalding.

Repeat deficiency

The adult family home did not notify the department when a resident eloped from the home. This failure placed the resident at risk for unmet safety and medical care needs.

The provider failed to demonstrate the understanding of his responsibility to ensure residents with active or historical wandering exit seeking and or elopement behaviors received the necessary supervision to remain safe. This failure placed the safety of these residents living at the home at risk of harm.

The adult family home failed to ensure one resident was free from neglect. Allowing the resident to continue unsafe elopement behaviors placed the resident at risk for serious injury. In addition, failure to provide necessary supervision for behaviors of wandering, exit-seeking and or elopement placed two residents at safety risk

The provider failed to ensure a resident was supervised by a qualified caregiver at all times when out of the home. This failure resulted in one resident sustaining a skin care when the resident was left unsupervised.

The provider failed to have a spare key to open one residents' bedroom. This placed the resident at risk of being unable to evacuate safely during an emergency.

The licensee failed to ensure they kept a log of accidents or incidents and did not document when a Resident eloped from the facility.

The licensee did not report a missing resident to the department hot line as required.

Repeat deficiency

The licensee did not record in the resident record when a resident eloped from the home and was found wandering on the street in the middle of the night.

The home failed to report two alleged incidents of possible abuse to the department and the police department for one resident. This failure placed the safety of all residents in the home at risk.

The provider failed to take adequate action to address the unsafe smoking of one resident there by failing to actively support the safety of six residents.

The Co-providers failed to ensure all toxic cleaning products were kept in inaccessible areas for residents who were not assessed as safe to use the products without supervision. This failure placed the residents at risk of inappropriate use of the material.

The Co-providers failed to have at least 3 gallons of drinking water for emergency use on site for each resident and household member and placed five residents at risk for dehydration had an emergency occurred and insufficient drinking water available.

Repeat deficiency

The home failed to ensure all grab bars were secure in the home. This failure caused a potential risk for falls by unsteady bars use by residents in both bathrooms

The home through the entity representative failed to ensure that two incidents involving one resident were logged. One incident where the resident expressed suicidal and homicidal thought and a second incident which resident of one resident biting had occurred. The failed to log the incidents potentially put the resident at risk of ongoing, unrecognized and unresolved patterns which could result in risk of abuse or neglect.

REPEAT DEFECIENCY
REPEAT DEFECIENCY

The provider failed to ensure the resident manager did not neglect a resident when the resident manager deliberately lied to the provider and family that the resident fell. This resulted in the resident sustaining a broken hip.

The adult family home failed to have a working telephone. This failure put the residents at risk of not reaching emergency care in a timely manner.

Repeat deficiency

The home did not have a common area for the bedrooms downstairs. This caused two residents to be without a common area.

The provider failed to provide the necessary care and services to help one resident reach the highest level of well-being in a manner that actively supported the safety of the resident when the resident was transferred in an unsafe manner not specified in the resident's negotiated care plan. This failure resulted in injury to the resident and caused the resident physical harm and mental distress.

The provider failed to follow the condition on the license of the adult family home to notify and involve the registered nurse consultant when one resident had a broken shoulder and a fall with a head injury. This prevented the registered nurse consultant from training the provider and staff how to meet the resident's care needs and updating the plan of care to meet the residents' needs.

The Co-providers failed to ensure an emergency evacuation floor plan was posted on the upper level of the adult family home and placed five

residents at risk if their caregivers were on the upper level of the home when an emergency occurred

Two residents were moved to the lower level of the house into unlicensed beds. Moving the residents to unlicensed area of the home placed the residents at risk for safety issues.

The facility failed to ensure the temperature in the dining room was 68° F worried by during waking hours

The licensee failed to meet business financial obligations by not paying the light bill in a timely manner. This failure caused the electricity at the adult family home to be turned off on November 3, 2010 for 4 to 5 hours causing inconvenience and discomfort for residents.

The licensee failed to ensure smoke detectors in a resident's bedroom was kept in working condition at all times.

The home failed to meet business liability insurance as required this failure placed four residents at risk of being unable to receive care related to bodily injury and or property damage in the event of injury by any employee or volunteer. This is a repeat uncorrected deficiency previously cited on January 11, 2011 and April 21 2011