



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

April 29, 2016

Janice T Angle
VALLEY VIEW ADULT FAMILY HOME
9440 S 207TH PLACE
KENT, WA 98031

RE: VALLEY VIEW ADULT FAMILY HOME License #307902

Dear Provider:

On April 28, 2016 the Department completed a review of communication and / or documents from you indicating that you have corrected the deficiency or deficiencies cited in the report/s dated April 5, 2016.

Based on the review of this information the Department finds the deficiency or deficiencies have been corrected. Your home meets the adult family home licensing requirements.

The Department staff who did the off-site verification:
Susan Aromi, Licensors

If you have any questions please, contact me at (253) 234-6007.

Sincerely,

Delores Usea, Field Manager
Region 2, Unit G
Residential Care Services



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

Statement of Deficiencies	License #: 307902	Completion Date
Plan of Correction	VALLEY VIEW ADULT FAMILY HOME	April 5, 2016
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You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

The department has completed data collection for the unannounced on-site full inspection of: 3/29/2016

VALLEY VIEW ADULT FAMILY HOME
9440 S 207TH PLACE
KENT, WA 98031

The department staff that inspected the adult family home:
Susan Aromi, BSN, RN, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032-2388
(253)234-6007

As a result of the on-site full inspection 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.

[Signature]
Residential Care Services

4-6-2016
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.

Janice J. Angle
Provider (or Representative)

4-14-2016
Date

RECEIVED
APR 15 2016
DSHS/ADSA/RCS

Statement of Deficiencies

License #: 307902

Completion Date

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VALLEY VIEW ADULT FAMILY HOME

April 5, 2016

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Licensee: JANICE ANGLE

WAC 388-76-10350 Assessment Updates required. The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

- (1) When there is a significant change in the resident's physical or mental condition;
- (2) When the resident's negotiated care plan no longer reflects the resident's current status, needs and preferences;

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the adult family home failed to have the assessment of one of two sampled residents (Resident #5) updated when the resident's negotiated care plan (NCP) no longer reflected his current status and needs, and when there were significant changes to the resident's condition. This placed the resident at risk of unmet needs.

Findings include:

Observations, interviews, and record reviews occurred on 03/29/2016.

Resident #5 sat in a [REDACTED] and used a [REDACTED]. The Resident Manager (RM) and Caregiver A transferred the resident to bed before lunch time. The RM started a [REDACTED] via the resident's [REDACTED] for lunch.

In interview, the resident said there was much he could not do anymore because of the rapid decline in his condition. He said he could not even use a call bell to ask for staff assistance, so he used an audio-monitoring device. The RM brought out a baby audio-monitor from a closet and said they turned this on every night for the resident.

The RM said the resident used to eat [REDACTED]. The RM said they gave the resident [REDACTED] three times a day, and crushed his medications and gave them [REDACTED] which was placed on [REDACTED]. The RM said the resident started using the [REDACTED].

Resident #5's current assessment documented the resident was able to feed self. The presence of a [REDACTED] were not addressed. The assessment indicated the resident took his medications whole with applesauce. The staff's crushing his medications and administering them through his [REDACTED] was not addressed. The resident's use of a [REDACTED] was not addressed. There was a signed consent for use of audio-monitoring that Resident #5 signed. The assessment did not address the resident's use of audio-monitoring at night.

The Provider said she needed to update Resident #5's assessment.

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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, VALLEY VIEW ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4-10-2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Note: Reflected in Resident #5 Assessment and NCP on 4-10-2016

Janice L. Angle
Provider (or Representative)

4-10-2016
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:

Based on observations, interviews and record reviews, the adult family home (AFH) failed to update the Negotiated Care Plan (NCP) for 1 of 2 sampled residents (Resident #5) when parts of the plan no longer addressed his care needs. This placed the resident at risk for unmet needs.

Findings include:

Observations, interviews and record reviews occurred on 03/29/2016.

Observation found Resident #5 in a [REDACTED] propelled by the caregivers (Resident Manager and Caregiver A). The resident had limited movement due to his medical condition. He used a [REDACTED]. The RM and Caregiver A transferred the resident to bed before lunch time, and the RM started him on a [REDACTED] for lunch.

In interview, the resident said there was much he could not do anymore because of the rapid decline in his condition. He said he could not even use a call bell to ask for staff assistance, so he used an audio-monitoring device. The RM brought out a baby audio-monitor from a closet and said they turned this on every night for the resident.

The RM said the resident used to eat [REDACTED]. The RM said they gave the resident [REDACTED] three times a day, and crushed his medications and gave them through his [REDACTED] which was placed on [REDACTED].

The resident's current NCP did not address the resident's change in medication management, use of audio-monitoring at night, and what care and services the AFH staff provided in relation to the issues.

The Provider said Resident #5 had a decline in his condition and had several changes to his care recently. She said she had not yet updated the resident's NCP.

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Attestation Statement

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Note: Reflected on Resident #5 Assessment and NCP on 4-10-2016

Janice J. Angle
Provider (or Representative)

4-10-2016
Date

WAC 388-76-10650 Medical devices. Before the adult family home uses medical devices for any resident, the home must:

- (1) Review the resident assessment to determine the resident's need for and use of a medical device;
- (2) Ensure the resident negotiated care plan includes the resident use of a medical device or devices; and
- (3) Provide the resident and family with enough information about the significance and level of the safety risk of use of the device to enable them to make an informed decision about whether or not to use the device.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the adult family home (AFH) did not determine the residents' need for and use of bed side rails and did not address the residents' use of the rails in the the negotiated care plan (NCP) for two of two residents (Residents #4 and #5). In addition, the residents were not informed of the safety risks associated with the side rail use. These failures prevented the two residents from making informed decisions about whether or not to use the side rails, and placed them at risk of harm.

Findings include:

Observations, interviews and record reviews occurred on 03/29/2016.

Observation of Resident #4's bed revealed bilateral one-half side rails bolted to the hospital bed frame. In separate interviews, Resident #4 and the Resident Manager (RM) said the resident used the rails for getting up from bed and positioning in bed. The RM said the resident had the rails since he moved in to the home. When asked if anyone at the AFH talked to him about the safety risks associated with bed rail use, Resident #4 said he did not remember.

Review of records revealed Resident #4 moved in to the AFH in [REDACTED] His current assessment did not include the need for and use of a half side rail. The resident's current NCP did not include the resident's use of side rails and the related safety plans. In addition, there was no documentation that the AFH informed the resident or the resident representative of the safety risks associated with side rail use.

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Resident #5 sat in a [redacted] propelled by the caregivers. He had limited movement due to his medical condition. The RM and Caregiver A transferred the resident to bed before lunch time. A 1/4 metal bed rail was propped against a table across the resident's bed. The RM said they put this rail on the left side of the resident's bed every night. When asked if the resident used the bed rail for transfers or bed repositioning, the RM stated, "No, he can't move anymore." When asked why they put the side rail on the resident's bed every night, the RM said it came with the hospital bed.

In interview, when asked if anyone at the AFH talked to him about the safety risks associated with bed rail use, Resident #5 said, "No".

Resident #5's current assessment did not include the need for and use of a half side rail. The resident's current NCP did not include the resident's use of side rails and the related safety plans. There was no documentation that the resident was informed of the risks of side rail use.

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, VALLEY VIEW ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4-10-2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Jamie J. Angle
Provider (or Representative)

4-10-2016
Date

Note: → Resident #4 - the use of side rails & safety plans was reflected on his NCP & assessment on 4-10-2016
→ Resident #5 - the side rails was taken off on 4-10-2016