



**Residential Care Services
Investigation Summary Report**

Provider/Facility: WILLOW CREEK AFH (686970) **Intake ID(s):** 3176608, 3176901
License/Cert. #: AF461700
Investigator: Arnold, Barbara **Region/Unit:** RCS Region 3/Unit A **Investigation Date(s):** 01/19/2016 through 02/04/2016
Complainant Contact Date(s): 01/25/2016, 01/26/2016, 02/10/2016

Allegations:

Named resident fell and no one was notified and medical attention was not obtained in a timely manner.

Investigation Methods:

- | | | | |
|--|---|--|---|
| <input checked="" type="checkbox"/> Sample: | 1 of 3 residents including named resident | <input checked="" type="checkbox"/> Observations: | Interaction of staff with residents
General observations of unit environment |
| <input checked="" type="checkbox"/> Interviews: | Residents
Staff | <input checked="" type="checkbox"/> Record Reviews: | Resident record
Incident reports
Policies
Employee records |

Allegation Summary:

Named resident did fall. Caregiver on duty at the time assisted the named resident to a chair, assessed for injury and applied first aid measures. Daughter, physician or resident manager were not notified timely of the incident. Physician and case manager were never notified by the home of the incident. Emergency medical services were not obtained for the named resident to be assessed. Treatment was not sought until the next day.

Unalleged Violation(s): Yes No
None

Conclusion: **Failed Provider Practice Identified** **Failed Provider Practice Not Identified**
See above

Action: **Citation(s) Written** **No Citation Written**
388-76-10225 Reporting requirements



**Residential Care Services
Investigation Summary Report**

388-76-10380 Negotiated care plan timing of review

RCPP Action: **Recommend Finding**

Recommend Close Investigation



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 PO Box 98907, Lakewood, WA 98496

RECEIVED
 FEB 25 2016
 DSHS RCS Region 3

Statement of Deficiencies	License #: 461700	Completion Date
Plan of Correction	WILLOW CREEK AFH	February 4, 2016
Page 1 of 4	Licensee: JJ&K	

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 complaint investigation of: 1/19/2016
 WILLOW CREEK AFH
 968 PERU AVE
 PORT ORCHARD, WA 98366

This document references the following complaint numbers: 3176608 , 3176901
 The department staff that inspected and investigated the adult family home:
 Barbara Leiter-Arnold, RN, Complaint Investigator

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

As a result of the on-site complaint investigation 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.

LR
LISA CRAMER
 Residential Care Services

2/19/16
 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.

J Schmidt
 Provider (or Representative)

2-23-16
 Date

2/23
4/3/16

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

- (a) The resident's family;
- (c) The resident's health care provider;
- (f) The resident's case manager if the resident is a department client.

This requirement was not met as evidenced by:

Based on interview and record review, the provider failed to ensure one of two resident's (Resident #6) representative, health care provider and case manager were immediately notified of a fall. This failure placed the resident at risk for not receiving treatment in a timely manner.

Findings include:

Resident #6 was admitted to the home on [REDACTED] 2014 with diagnoses of [REDACTED] and other diagnoses as listed in the record.

On 01/02/2016 around lunch time Resident #6 got up from the table, picking up her plate and cup and proceeded to carry them away from the table. Resident # 5 cautioned Resident #6 not to carry the plate and cup away from the table. Staff C heard Resident #5 and came into the room from the office just as Resident #6 lost her footing and fell. Staff C assisted Resident #6 to a recliner. Staff C noticed several skin tears and treated each with first aid measures. Range of motion was performed and no decline was noted. Elbow of the [REDACTED] arm was red in color and ice was applied. It was unclear if Staff C was aware residents with [REDACTED] did not always identify pain.

Staff C was unclear during an interview on 02/04/2016 when she called the resident's daughter. Staff C stated that it was sometime the day of the incident but she was unsure of the time. She (Staff C) stated she left a message for the daughter to call the home. Staff C did not make any other attempts to reach the daughter.

Collateral contact, during an interview on 01/26/2016, stated she did not receive a call on Saturday (01/02/2016), nothing was in her voice mail and nothing appeared under the list of numbers received that day on her phone.

Staff C attempted to call her resident manager (Staff B) sometime during the day but was unclear as to the time. She (Staff C) did not get a response from resident manager.

Staff B, during an interview on 01/19/2016, was unsure when she heard about the fall.

On Sunday, 01/03/2016, Staff C noticed Resident #6's [REDACTED] was swollen and hot to the touch. Staff C called Resident #6's daughter and informed her of the fall. The daughter came to the home and picked her mother and took her for evaluation. The daughter was not given any medication for Resident #6 when she left the home.

The daughter was informed; following the evaluation, Resident #6 had a broken [REDACTED]. The resident did not return to the home, but went home with the daughter.

Staff C was unsure if she informed the resident manager the resident had not returned to the home.

Staff B was unable to state when she was informed the resident was not in the facility.

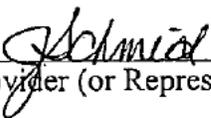
Case manager stated that she believed Staff B was unaware the resident was not in the home when called on Monday 01/04/2016.

Staff C did not notify the physician of the fall. Staff C did not leave a message for the case manager concerning the fall.

Case manager received a voice mail on Monday (01/04/2016) from the resident's daughter stating her mother had fallen and she would not be sending her mother back to the home. She (case manager) called the facility to find out what happened.

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, WILLOW CREEK AFH is or will be in compliance with this law and / or regulation on (Date) 2-23-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

2-23-16

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 record review and interview, the provider failed to ensure the written negotiated care plan (NCP) of one of two residents (Resident #6) was updated to accurately reflect the current need for a safety plan around the resident removing tableware. This failure placed the resident at risk for falls.

Findings include:

Resident #6 was admitted to the home on [REDACTED] 2014 with diagnoses of [REDACTED] and other diagnoses as listed in the record. Resident #6 had a fall 10/19/2014 while in the shower that resulted in a fractured shoulder.

According to Staff B, C, and Resident # 5, Resident #6 would frequently get up from the table, taking her plate and cup with her. Due to her dementia she would leave these at various places throughout the house.

Resident #6's negotiated care plan did not address the issue of the resident removing her plate and cup from the table after eating. Because no intervention was in place, the other residents of the facility would call out to notify the staff of Resident #6's behavior.

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, WILLOW CREEK AFH is or will be in compliance with this law and / or regulation on (Date) 2-23-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

J. Schmid
Provider (or Representative)

2-23-16
Date



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98907, Lakewood, WA 98496

April 13, 2016

JJ&K ENTERPRISES
WILLOW CREEK AFH
960 Peru Avenue
Port Orchard, WA 98366

RE: WILLOW CREEK AFH License #461700

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 8, 2016 for the deficiency or deficiencies cited in the report/s dated February 4, 2016 and found no deficiencies.

The Department staff who did the inspection:
Emily Vincent, AFH Licenser
Barbara Leiter-Arnold, Complaint Investigator

If you have any questions please, contact me at (253) 983-3826.

Sincerely,

Lisa Cramer, Field Manager
Region 3, Unit A
Residential Care Services