



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
316 W Boone Ave., Suite 170, Spokane, WA 99201

May 2, 2016

Carlene M Henderson
Dennis W Henderson
RENAISSANCE ADULT HOME CARE
3430 S LINKE RD
GREENACRES, WA 99016

RE: RENAISSANCE ADULT HOME CARE License #47801

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 29, 2016 for the deficiency or deficiencies cited in the report/s dated March 23, 2016 and found no deficiencies.

The Department staff who did the inspection:
Rose Anderson, Licensor

If you have any questions please, contact me at (509) 323-7324.

Sincerely,

Susan Bergeron, Field Manager
Region 1, Unit B
Residential Care Services

Statement of Deficiencies	License #: 47801	Completion Date
Plan of Correction	RENAISSANCE ADULT HOME CARE	March 23, 2016
Page 2 of 8	Licensor: CARLENE HENDERSON	

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home failed to ensure medicated cream was delegated for 1 of 1 resident with skin issues (#1) in a sample of 4. The deficient practice may result in prolonged wound healing and discomfort. Findings include:

Nurse delegation allows for caregivers to administer treatments under the direction of a registered nurse. The nurse delegator is responsible for assessing the resident's needs, providing specific written instructions to caregivers including how and when to provide the treatment, and what symptoms or complications to watch for. Adult family home staff are required to notify the nurse delegator when the resident's needs or condition changes.

Per record review and interview on 03/15/15, Resident #1 was alert/oriented to self, had two wounds to buttock area, required assistance with medications, and cuing with position changes.

On 03/15/15 Resident #1 was observed to use a walker for mobility, and receive assistance by staff in the bathroom.

Record review of practitioner visit on 03/11/16 showed the resident was seen for complaints of soreness to his buttock area. He was diagnosed with a Stage 1 (persistent redness of intact skin), and Stage 2 (partial thickness skin tissue loss) pressure ulcers.

Per review of 03/11/16 practitioner order, [REDACTED] ointment (an ointment used to treat and prevent skin issues) was to be applied twice daily, and as needed by staff. Documentation on the medication log showed staff initialed the medication as having been applied twice daily.

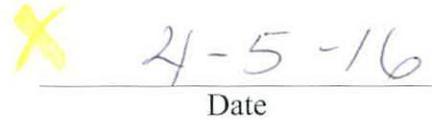
Resident #1 was interviewed, and stated staff had been applying ointment to his buttock area for treatment of wounds. He declined skin observation at that time by registered nurse licenser.

Per interview, Caregiver C stated the ointment had been applied twice daily by staff and nurse delegation was not provided. Staff B was interviewed and stated she was aware of the ointment order, but did not realize there was an open area on the resident's skin. After the licenser identified the concerns, she verified the application of the ointment should be delegated.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 4-3-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.


Provider (or Representative)


Date

WAC 388-76-10470 Medication Timing Special directions.

(2) The home must ensure all directions given by the practitioner are followed when assisting or giving each resident medication. This includes but is not limited to:

- (a) Before meals;
- (b) After meals;
- (c) With or without food; and
- (d) At bed time.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the adult family home failed to provide medication at the time the practitioner ordered for 1 of 2 residents reviewed for medications (#2), in a sample of 4. Findings include:

Resident #2, per record review, was alert/oriented and required assistance with medications. The resident was admitted to the home in February 2016.

The resident's March 2016 medication log was reviewed and contained instructions for a blood pressure medication to be taken daily [REDACTED]. The log was printed from a pharmacy and originally instructed the staff to give the medication at bedtime. The typed instructions were crossed off and handwritten instructions were added to give the medication in the morning.

Caregiver C was interviewed on 3/15/16 and verified he gave the medication in the mornings. Staff B commented the resident's family told the home the resident took the medication in the morning when she lived at home.

Further record review identified on 1/26/16, the medication was ordered to be given at bedtime. The medication supply was reviewed and the current pharmacy label instructed the medication to be given at bedtime.

The blood pressure medication was not given as instructed. Staff verified they had not consulted with the practitioner regarding changing the time of day the medication was given.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 4-1-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

X Carlene Henderson
Provider (or Representative)

X 4-5-16
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:
 - (c) Dosage of the medication;
 - (d) Frequency which the medications are taken; and

This requirement was not met as evidenced by:

Based on interview and record review, the home failed to ensure the medication log was complete with dosage and frequency for 2 of 4 sample residents (#1, 2). The deficient practice has the potential to cause a medication error. Findings include:

1. Per interview and record review, Resident #1 was alert/oriented to self, had two wounds to his buttock area, was frequently [REDACTED] and required assistance with toileting and medications.

Review of practitioner notes show resident was seen on 03/11/16, and had a diagnosis of Stage 1 (persistent redness of intact skin), and Stage 2 (partial thickness skin tissue loss) pressure ulcers to buttock areas. Treatment order was written for [REDACTED] (an ointment used to treat and prevent skin issues) to be applied by caregivers a minimum of twice daily and as needed.

Review of the medication log showed order for [REDACTED] to be applied twice daily, but did not include the as needed dose. The medication was signed as given twice daily during the month, and there was no documentation to show it was received as needed.

Staff C was interviewed, and verified the ointment was being applied twice daily.

Medication log and orders were reviewed with Staff B. She verified the orders were not written correctly on the medication log, and did not contain the as needed dose.

2. Resident #2, per record review, was alert/oriented and required assistance with her medications. The resident received a blood thinning medication daily [REDACTED] and routine blood levels were performed by an outside agency. The outside agency monitored the laboratory results and adjusted the resident's [REDACTED] dosage based on the blood levels.

The pharmacy label documented the resident's current [REDACTED] dose as 5 mg three times a week (Sunday, Tuesday, Friday) and 3.75 mg the other days.

The resident's March 2016 medication log was reviewed and identified the resident received [REDACTED] on a daily basis. The instructions were to "follow dosing chart". When the staff initialed the [REDACTED] as given, they wrote the milligrams by their initials. However, the log did not identify the different doses on specific days and/or the date the Coumadin dosage was changed.

The medication log was not updated on an ongoing basis with the changes in the [REDACTED] dosage and the instructions did not contain the current dosage and/or the days each was received.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 3-25-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Carlene Henderson
Provider (or Representative)

4-5-16
Date

WAC 388-76-10585 Resident rights Examination of inspection results.

(1) The adult family home must place the following documents in a visible location in a common use area where they can be examined by residents, resident representatives, the department and anyone interested without having to ask for them.

(b) A copy of all complaint investigation reports, and any related cover letters received since the most recent inspection or not less than the last twelve months.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the adult family home failed to ensure complaint investigation results from December 2015 were accessible to resident and visitors.

Findings include:

On 3/15/16 a notebook labeled inspection results was on a table in the dining room. The notebook contained inspection results from the last full inspection in 2014. However, the home had a complaint investigation with results in December 2015 and the results were not in the notebook.

Staff member B was interviewed at the time and stated she would look for the results. The staff member found the follow up inspection results dat0de February 2016, but she was unable to locate the report and cover letters from the complaint investigation in December 2015.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 3-15-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Carlene Henderson
Provider (or Representative)

4-5-16
Date

WAC 388-76-10795 Windows.

(6) The home must ensure that each basement and each resident bedroom window, that meets the requirements of subsection (1), (2) and (3) of this section, are kept free from obstructions that might block or interfere with access for emergency escape or rescue.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the adult family home failed to ensure the bedroom windows were not obstructed to prevent emergency access for 3 of 5 resident rooms (#1,3,4). Findings include:

1. Resident #1, per record review, was alert/oriented, required assistance with most activities of daily living and evacuation.

The resident was observed on 3/15/16 to walk with a walker and stand by staff assistance. He lived in a private room with one window that met the emergency egress requirement. Alongside the window was an [REDACTED] recliner, with the foot of the bed adjacent to the other side of the recliner. The recliner was heavy, positioned between the bed/window and could not be slid to the side to access the window.

2. Resident #3, per record review, was alert/oriented, required assistance with most activities of daily living, and evacuation.

The resident was observed on 3/15/16 to use a wheel chair for mobility. He lived in a private room with one window that met the emergency egress requirement. In front of the window was a small dresser with his television on top. The dresser was in front of the opening portion of the window and would potentially hinder emergency escape.

3. Resident #4, per record review, was alert, required assistance with most activities of daily living and emergency escape.

The resident was observed on 3/15/16 to self propel his wheel chair. He lived in a private room with one window that met the emergency egress requirement. In front of the window was a desk the resident used to store items. The desk blocked most of the window, including the part that opened.

Staff were interviewed at the time and did not realize the furniture was considered an obstruction for emergency escape.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 3-15-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Carlene Henderson 4-5-16
Provider (or Representative) Date

WAC 388-76-10825 Space heaters and stoves. The adult family home must ensure:

- (1) The following space heaters are not used in a home except during a power outage and the portable heater is only safe source of heat:
- (d) Electric.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the adult family home failed to ensure space heaters were used only during an emergency. Findings include:

Resident #2, per record review, was alert/oriented, independent with activities of daily living, and required assistance with medications.

The resident's room was observed on 3/15/16. She lived alone in the room and a space heater was plugged in, but not running. She said the heater shut itself off at times, but was used to help keep her room warm. The resident said a staff member gave it to her "a couple of weeks ago."

WRONG

Staff members B and C were interviewed at the time regarding the space heater. Neither was aware of where the heater came from and did not recall seeing it before. The heater was removed after the licenser identified the concern.

over night caregiver stated that they were unaware of heater not being allowed in room w/ resident. At resident's request caregiver brought heater to resident #2 room on 3-12-16. Heater was in room from 3-12-16 - 3-15-16 then removed.

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, RENAISSANCE ADULT HOME CARE is or will be in compliance with this law and / or regulation on (Date) 3-15-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Carlene Henderson
Provider (or Representative)

4-5-16
Date