



**Residential Care Services
Investigation Summary Report**

Provider/Facility: EMERALD AFH (687375) **Intake ID(s):** 3181494
License/Cert. #: AF750167
Investigator: Odachowski, Christine **Region/Unit:** RCS Region 2/Unit F **Investigation Date(s):** 01/22/2016 through 01/29/2016
Complainant Contact Date(s): 01/22/2016, 01/26/2016, 01/29/2016

Allegations:

1. Named Resident #1 needs turning every two hours, and this is not happening.
 2. Named Residents #1 and #2 say caregivers never come in, don't check on them and don't do anything for them.
 3. Named Residents #1 and #2 must call caregivers by cell phone for help.
 4. Named Resident #2 said she must prepare food for herself and Resident #1.
 5. Named Resident #1 is not assisted to the bathroom and told to just go in her Depends.
 6. Named Resident #1 never leaves her bed.
 7. Named Resident #1 said the food is disgusting.
 8. Named Resident #1 has not had a shower since admission.
 9. Named Resident #1's hair is unkempt.
 10. Concern how Named Resident #1 would be evacuated with one person.
 11. A caregiver is not supposed to trim Resident #1's toenails.
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Investigation Methods:

Sample: Four of four current residents. One closed record review.

Observations: Staff to resident interactions, common areas, caregiver quarters, resident rooms, assistive devices, stored food, meal service, resident appearance, behavior and mobility, outside agency resident care, resident skin condition, staffing and staffing availability, grounds

Interviews: Residents and resident representative, staff, others not associated with the home

Record Reviews: Resident records, adult family home (AFH) policy, incident log



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Allegation Summary:

1. Named Resident #1 said she could turn herself, moved herself in bed a lot and did not spend much time in one position. The Provider said the resident was turned every two hours unless the resident refused.
2. Caregivers were observed to enter resident rooms on several instances to initiate a variety of care services, such as hygiene and food service, for the named and sampled residents.
3. Based on observation and interview the AFH did not provide a system for residents to call for assistance.
4. Named Residents #1 and #2 said only caregivers prepared food. The Provider said residents did not prepare food.
5. Named Resident #1 said it was too much of a project to go to the bathroom and was not told to go in her Depends.
6. Named Resident #1 was observed to be moved out of bed with the assistance of one person, a physical therapist. The Provider said staff had offered to move the resident out of bed in the past and the resident did not want to. Named Resident #1 said she never asked to get out of bed and stayed there by choice and necessity.
7. A variety of nutritious stored foods and a served meal were observed. Named Resident #1 said alternate food choices were observed by her.
8. Named Resident #1 said a shower was too much of a project and received a sponge bath daily, as per her choice.
9. The named and sampled residents were well-groomed and appropriately dressed.
10. The Provider said named Resident #1 could be evacuated with one person. The resident was seen to be transferred out of bed with one person. A Department representative said because the resident was stronger she was a one person assist and she was awaiting a physical therapy report to confirm this.
11. The Provider said named Resident #1's toenails were trimmed by her sister. The named Resident's toenails were observed to be neatly trimmed without signs of skin or nail issues. Who would trim the resident's toenails was unspecified in the resident's assessment.

Unalleged Violation(s): **Yes** **No**

Based on observation, interview and record review the AFH did not use side rails in accordance with regulation for Named Resident #1 and and one sampled resident.

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

Failed practice identified.

Action: **Citation(s) Written** **No Citation Written**

WACs 388-76-10685-11 Bedrooms, 388-76-10650 Medical devices



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RCPP Action: **Recommend Finding**

Recommend Close Investigation



**Residential Care Services
Investigation Summary Report**

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

Failed practice identified.

Action: **Citation(s) Written** **No Citation Written**

WACs 388-76-10685-11 Bedrooms, 388-76-10650 Medical devices

RCPP Action: **Recommend Finding** **Recommend Close Investigation**



**Residential Care Services
Investigation Summary Report**

Provider/Facility: EMERALD AFH (687375) **Intake ID(s):** 3172597
License/Cert. #: AF750167
Investigator: Odachowski, Christine **Region/Unit:** RCS Region 2/Unit F **Investigation Date(s):** 01/22/2016 through 01/29/2016
Complainant Contact Date(s): 01/26/2016, 01/29/2016

Allegations:

A named Resident has dermatitis and does not get changed at night.

Investigation Methods:

Sample: Four of four current residents. One closed record review.

Observations: Staff to resident interactions, common areas, caregiver quarters, resident rooms, assistive devices, stored food, meal service, resident appearance, behavior and mobility, outside agency resident care, resident skin condition, staffing and staffing availability, grounds

Interviews: Residents and resident representative, staff, others not associated with the home

Record Reviews: Resident records, adult family home (AFH) policy, incident log

Allegation Summary:

The named and sampled residents were well-groomed and appropriately dressed. The home was clean and without foul odors. The Provider said the named Resident requested not to be changed at night unless she called for this assistance herself, which she did with the use of her cell phone. The Provider also said the named Resident had dermatitis on admit to the AFH and it had since resolved. The named Resident was observed to be without skin issues, had clean bed linen, and hygiene and preventative skin care was observed given by AFH staff. The named Resident said she called for help on her cell phone and it was always answered. The named Resident said she was changed when it was needed.



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Unalleged Violation(s): **Yes** **No**

Based on observation and interview the AFH did not provide a system for residents to call for assistance. Based on observation, interview and record review the AFH did not use side rails for the named and one sampled resident in accordance with regulation.

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

Failed practice identified.

Action: **Citation(s) Written** **No Citation Written**

WACs 388-76-10685-11 Bedrooms, 388-76-10650 Medical devices

RCPP Action: **Recommend Finding** **Recommend Close Investigation**



**Residential Care Services
Investigation Summary Report**

Provider/Facility: EMERALD AFH (687375)

Intake ID(s): 3150385

License/Cert. #: AF750167

Investigator: Odachowski, Christine

Region/Unit: RCS Region 2/Unit F

Investigation Date(s): 01/22/2016 through
01/29/2016

Complainant Contact Date(s): 01/22/2016

Allegations:

A named Resident fell and had multiple bruises.

Investigation Methods:

Sample:

Four of four current residents. One closed record review.

Observations:

Staff to resident interactions, common areas, caregiver quarters, resident rooms, assistive devices, stored food, meal service, resident appearance, behavior and mobility, outside agency resident care, resident skin condition, staffing and staffing availability, grounds

Interviews:

Residents and resident representative, staff, others not associated with the home

Record Reviews:

Resident records, adult family home (AFH) policy, incident log



**Residential Care Services
Investigation Summary Report**

Allegation Summary:

The named Resident no longer lived at the AFH. The Provider and the named Resident's representative said the resident bruised easily. The Provider said the resident was on a medication which increased her tendency to bruise. The Provider said, and the incident log showed, the named Resident had a fall before the bruises were noted. The Provider said prior fall prevention measures had been in place, the resident declined to call for help when she got up, and the resident had not fallen in the previous two years. At the time of the fall, the resident was assessed as independent with mobility. The Provider said she found the resident on the floor during a routine check, sent her for a medical evaluation, and the resident did not sustain injury other than bruises. The Provider said she had no reason to suspect abuse of the named Resident. No signs of injury were seen on any sampled residents, who stated they felt well-treated.

Unalleged Violation(s): **Yes** **No**

Based on observation and interview the AFH did not provide a system for residents to call for assistance. Based on observation, interview and record review the AFH did not use side rails for the named and one sampled resident in accordance with regulation.

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

Failed practice identified.

Action: **Citation(s) Written** **No Citation Written**

WACs 388-76-10685-11 Bedrooms, 388-76-10650 Medical devices

RCPP Action: **Recommend Finding** **Recommend Close Investigation**



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 #: 750167	Completion Date
Plan of Correction	EMERALD AFH	January 29, 2016
Page 1 of 5	Licensee: ESTRELLA DOMINGO	

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: 1/22/2016

EMERALD AFH
 12029 SE 209TH ST
 KENT, WA 98031

This document references the following complaint numbers: 3150385 , 3172597 , 3176129 , 3181494

The department staff that inspected and investigated the adult family home:

Christine Odachowski, BSN, Complaint Investigator

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

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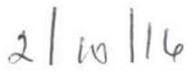
As a result of the on-site complaint investigation the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.


 Residential Care Services


 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.


 Provider (or Representative)


 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 observation, interview and record review the adult family home (AFH) failed to ensure two of five residents (Resident #3 and Former Resident #5) used side rails in accordance with regulation. This failure placed the residents at risk of harm.

Findings include:

Observations, interviews and record reviews occurred on 1/22/16 unless otherwise noted.

RESIDENT #3

Resident #3 was observed in bed. While the resident was in bed, two side rail devices of equal length, one on each upper side of the the bed, were observed. Eight vertical metal bars were observed on the side rail closest to the interior of the room.

Record review of an assessment dated 10/1/15 for Resident #3 showed the resident had [REDACTED] as well as other medical conditions, and [REDACTED] conditions. The use of side rails was not revealed in the assessment.

Record review of a NCP dated 11/11/15 For Resident #3 showed the notation "bed rails."

Interview on 1/26/16 with a Department case manager revealed the Provider had not called the Department case manager about side rail use by Resident #3.

Record review of Department records on 1/16/16 showed no discussion about side rails between the Provider and the Department case manager.

Resident #3 said she had not been told of specific risks associated with side rail use. The resident commented, "I can't imagine of any risks."

The Provider said Resident #3 had side rails on her bed since she was admitted to the AFH, and used them to turn. The Provider said the resident was not assessed for side rail use in the AFH. The Provider said she had not discussed the risk of side rail use with the resident.

FORMER RESIDENT #5

Record review of an assessment dated 11/18/16 for Former Resident #5 showed the resident had medical and cognitive conditions, and used [REDACTED] at all times. The assessment

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also stated the resident made poor decisions and required the extensive assistance of one person to transfer. The use of side rails was not revealed in the assessment.

Record review of a NCP dated 11/25/14 for Former Resident #5 did not reveal side rail use.

On 1/26/16 a representative of Former Resident #5 said the resident had side rails on her bed.

On 1/26/16 a person not associated with the AFH said bed rails were seen in the up position on Former Resident #5's bed on four different days.

On 1/28/16 the Provider said a doctor asked her to use a side rail on Former Resident #5's bed so the resident would not get up. The Provider also said the resident's bed had one side rail on it, and it had been in use since approximately the latter part of November 2015.

SUMMATION

The Provider did not ensure Resident #3 was assessed for side rail use, did not contact her assessor, the case manager, about the rails, and did not inform the resident of the risks of their use.

The Provider did not ensure Former Resident #5 was assessed for side rail use and did not include side rail use in her NCP.

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, EMERALD AFH is or will be in compliance with this law and / or regulation on (Date) 2/10/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.


Provider (or Representative)

2/10/16
Date

WAC 388-76-10685 Bedrooms. The adult family home must:

(11) Provide a call bell or intercom system if the provider, entity representative, resident manager or caregiver bedroom is not within hearing distance of each resident bedroom and the system is required by the department;

This requirement was not met as evidenced by:

Based on observation, interview and record review the adult family home (AFH) failed to provide a reliable call system for four of four current residents (Residents #1-#4). This failure placed the residents at risk for unmet needs.

Findings include:

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Observations, interviews and record reviews occurred on 1/22/16 unless otherwise noted.

The Provider said she lived in the AFH in a back area of the home that was separate from the area the residents lived in. The Provider said only she and Caregiver A worked regularly at the AFH. The Provider said Caregiver A's schedule was 7:00 a.m. until 7:00 p.m Monday through Friday, and only the Provider was regularly scheduled to work weekends. The Provider said on the current day, she was in the AFH as the sole caregiver after 3:00 a.m. until the arrival of Caregiver A.

Observation did not reveal any AFH call bell devices in the rooms of Residents #1, 2, 3, and 4.

Observation showed the front door opened into a living room common area. Off the dining area, which was part of the living room, was a room shared by Residents # and #. On the opposite side of the living room was a hallway off of which were located the rooms of Residents # and #. At the end of the hall was a closed door. Beyond the door was a bed.

The Provider told the investigator the bed in the above paragraph, on the opposite side of the closed door at the end of the hall, was a caregiver bed.

After the caregiver bed, a hallway was observed which led to a common area/kitchen area. There was a hall beyond the kitchen area that led to a bedroom.

The Provider said the bedroom off the end of the kitchen in the above paragraph was where she slept, and all quarters beyond the closed door at the end of the hall were that of caregivers.

There was an approximately 130 foot distance observed between the room of Residents # and # and the Provider's bedroom.

When asked how residents called for help, the Provider stated she made sure residents were okay before she went to the caregiver quarters. The Provider said she did not think she could hear Residents #1-4 make any noise while she was in her bedroom.

Caregiver A said residents did not have a call bell, and she did not use a cell phone for resident communication. When asked how residents called for help, Caregiver A said Resident # would come out of his room and call her name.

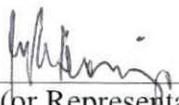
Resident # said he called for help by knocking on the caregiver door and the knock was not always answered. The resident said on one instance his knock was not answered after he had fallen and gotten himself up.

Resident # said he did not have a call bell and the way he called for help was to walk down the hall to the caregiver room and "bang on the door." The resident added "even then they don't answer sometimes."

This citation was discussed with the Provider.

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, EMERALD AFH is or will be in compliance with this law and / or regulation on (Date) 2/10/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

2/10/16

Date

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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

March 22, 2016

Estrella A Domingo
EMERALD AFH
12029 SE 209TH ST
KENT, WA 98031

RE: EMERALD AFH License #750167

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on March 22, 2016 for the deficiency or deficiencies cited in the report/s dated January 29, 2016 and found no deficiencies.

The Department staff who did the inspection:
Christine Odachowski, Complaint Investigator
Pamela Osterman, Complaint Investigator

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

Sincerely,

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