



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

March 17, 2016

VALLEY PINES RETIREMENT HOME LLC  
VALLEY PINES RETIREMENT HOME LLC  
12022 EAST MAXWELL AVE  
SPOKANE VALLEY, WA 99206

RE: VALLEY PINES RETIREMENT HOME LLC License #751002

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on March 16, 2016 for the deficiency or deficiencies cited in the report/s dated December 23, 2015 and found no deficiencies.

The Department staff who did the inspection:  
Connie Davis, 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



STATE OF WASHINGTON  
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
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 316 W Boone Ave., Suite 170, Spokane, WA 99201

Statement of Deficiencies	License #: 751002	Completion Date
Plan of Correction	VALLEY PINES RETIREMENT HOME LLC	December 23, 2015
Page 1 of 3	Licensor: VALLEY PINES	

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:  
 12/21/2015 and 12/23/2015

VALLEY PINES RETIREMENT HOME LLC  
 12022 EAST MAXWELL AVE  
 SPOKANE VALLEY, WA 99206

The department staff that inspected the adult family home:  
 Mara Ryan, BSW, Licensor

From:  
 DSHS, Aging and Long-Term Support Administration  
 Residential Care Services, Region 1, Unit B  
 316 W Boone Ave., Suite 170  
 Spokane, WA 99201  
 (509)323-7303

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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.

*Susan Benjamin*  
 Residential Care Services

12/29/15  
 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.

*Jerry Lowell*  
 Provider (or Representative)

2/13/2016  
 Date

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

- (3) The care and services in a manner and in an environment that:
- (b) Actively supports the safety of each resident; and

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the adult family home failed to ensure care and services were provided to promote resident safety related to the use of a hot pack for 1 of 5 sample residents (#1). Findings include:

Resident #1 was alert, had memory problems and required assistance with some activities of daily living. The resident had diagnoses including a disease characterized by the progressive

According to the 9/18/15 assessment, the resident was resistant to care and wanted to be as independent as possible. The assessment also noted the resident required supervision at times because her decision making was poor.

Per record review, the resident complained of back pain on 11/19/15 and was sent to the hospital. She returned to the adult family home with a new order for pain medication and instructions to follow up with her primary care physician. Caregiver B said a hot pack was purchased at that time, after the physical therapist recommended it for the resident.

On 11/24/15, the practitioner visited the resident secondary to continued complaints of back pain. During the assessment the practitioner found a third degree burn on the resident's left lumbar region. Pain medications were ordered and caregivers were directed to leave the area open to air.

Per an 11/24/15 entry in the incident log, Caregiver C observed the resident standing by the microwave putting the hot pack in and taking it out. On 11/27/15 Caregiver B documented that staff was unaware of the burn because the resident had not complained of any pain/discomfort and the resident was applying the hot pack herself. The caregiver said it was difficult to determine what date the resident burned herself because she didn't like to have any assistance with dressing or toileting.

On 12/23/15, the resident's back was observed as slightly discolored but healed. The resident said she still experienced some pain but was not able to say whether it was related to her burn.

The home was aware the resident required supervision with decision making and did not assess the resident's ability to manage the hot pack safely.

Statement of Deficiencies

License #: 751002

Completion Date

Plan of Correction

VALLEY PINES RETIREMENT HOME LLC

December 23, 2015

Page 3 of 3

Licensee: VALLEY PINES

**Attestation Statement**

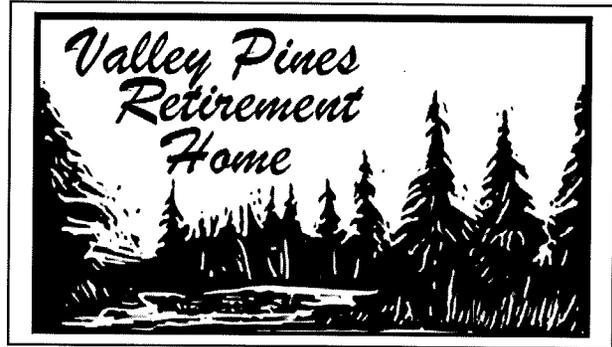
I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, VALLEY PINES RETIREMENT HOME LLC is or will be in compliance with this law and / or regulation on (Date) 11/24/2015. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

  
\_\_\_\_\_  
Provider (or Representative)

2/13/2016  
\_\_\_\_\_  
Date

2/13/2016

Valley Pines Retirement Home  
12022 E. Maxwell Ave.  
Spokane Valley, WA 99206



### Attestation (plan of correction)

This attestation is to address the RCS citation issued on Valley Pines Retirement Home as a result of the inspection conducted on December 23<sup>rd</sup>, 2015. The report of the citation was received by me on January 26<sup>th</sup>, 2016.

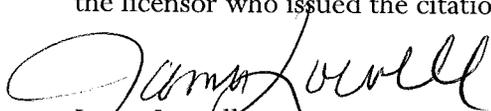
Please accept my apologies for not providing this attestation to you within the compulsory 10 calendar day timeframe. The inspection only resulted in a single citation and I am currently in the process of appealing the severity of the citation with IDR and OAH, as recommended by Ms. Bergeron. I erroneously believed that the due date of the attestation would be postponed until the appeal process was completed for the citation, as is typical for litigated appeals of legal judgments.

The actual incident cited occurred about a month prior to the inspection, on November 24<sup>th</sup>. The licenser became aware of it as a result of reading our detailed description of it in our AFH's incident log, where all incidents in our adult home are routinely logged.

At that time, once I became aware that the resident had sustained a skin burn as a result of heating the hot pack on her own, our Plan of Correction was:

1. To discontinue its use.
2. To establish a policy at VPRH that any future recommended use of heat therapy would be subject to strict monitoring by the staff, regardless of their level of cognizance.

The reason for setting the bar high for this, relative to a given resident's level of cognizance, is because the resident that was impacted by this citation had a history of knowing when something (such as coffee, etc) was excessively hot, making the incident cited "highly unusual", in the words of the licenser who issued the citation.

  
James Lowell  
Provider, VPRH Ph: 879-4145

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FEB 16 2016

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