STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

January 22, 2020

A BEAUTIFUL PLACE INC
A BEAUTIFUL PLACE INC
5009 COLBY AVE
EVERETT, WA 98203

RE: A BEAUTIFUL PLACE INC License #752486

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on January 17, 2020 for the deficiency or deficiencies cited in the report/s dated December 10, 2019 and found no deficiencies.

The Department staff who did the inspection:
Karen Glover, Complaint Investigator

If you have any questions please, contact me at (360) 651-6872.

Sincerely,

Shelly Scarboro, Field Manager
Region 2, Unit B
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: A BEAUTIFUL PLACE INC (779976) **Intake ID(s):** 3674373

License/Cert. #: AF752486

Investigator: Glover, Karen **Region/Unit:** RCS Region 2/Unit B **Investigation Date(s):** 10/29/2019 through 12/10/2019

Complainant Contact Date(s): 10/28/2019, 10/31/2019, 11/05/2019

Allegations:

1. The named resident did not receive a pressure relieving mattress as ordered by the home health nurse.

Investigation Methods:

[X] **Sample:**	Four residents including the named resident.	[X] **Observations:**	Environment, staff/staff interactions, staff/resident interactions, resident/resident interactions and care provision.
[X] **Interviews:**	Staff, residents and others not associated with the facility.	[X] **Record Reviews:**	Incident reports, resident records and facility records.

Allegation Summary:

1. The named resident was observed lying in bed on a deflated and wrinkled "waffle" mattress (inflatable prevention mattress). The adult family home (AFH) staff were not aware the deflated mattress was on the bed. The named resident was a two person assist for care and transfers. Observed the AFH only staffed with one person during the night shift with no ability to safely transfer,provide care or have the ability to adhere to a turn schedule for the named resident. The AFH failed to have an appropriate pressure relieving mattress on the named resident's bed.

Unalleged Violation(s): [X] **Yes** [ ] **No**

Additional deficiencies not related to the original complaint were identified. See SOD dated 12/02/19.

Conclusion / Action: [X] **Failed Provider Practice Identified / Citation(s) Written** [ ] **Failed Provider Practice Not Identified / No Citation Written**

WAC 388-76-10400 Care and Services (2)(3)(a)(b)

WAC 388-76-10195 Adult Family Home Staff (1)

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Statement of Deficiencies	License #: 752486	Completion Date
Plan of Correction	A BEAUTIFUL PLACE INC	December 10, 2019
Page 1 of 6	Licensee: A BEAUTIFUL PLACE INC	

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: 10/29/2019, 11/5/2019 and 11/15/2019

A BEAUTIFUL PLACE INC
5009 COLBY AVE
EVERETT, WA 98203

This document references the following complaint number: 3674373

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

Karen Glover, RN, Complaint Investigator
Kelly Howard, RN, MSN, Licensor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223
(360)651-6872

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.

Jennifer Watson — 12/13/19

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.

Dorrie Ho — 12/24/19

Provider (or Representative) — Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:
(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.
(3) The care and services in a manner and in an environment that:
(a) Actively supports, maintains or improves each resident's quality of life;
(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 (AFH) failed to ensure one of four residents (Resident #1) received the necessary care and services to prevent skin breakdown and to ensure safety and comfort. This failure placed Resident #1 at risk for skin breakdown, compromised wound healing and a diminished quality of life.

Findings included...

Record review showed Resident #1 was admitted on [redacted]17 with multiple diagnoses including [redacted] and [redacted]

Record review of Resident #1's assessment dated 12/26/18 showed Resident #1 required two staff to assist with transfers using a [redacted] Resident #1 was incontinent of bowel and bladder, and required two staff to perform all toileting care. Resident #1 had chronic dry skin and Resident #1's skin was intact over all pressure areas. Record review of Resident #1's negotiated care plan (NCP) dated 08/08/19 directed staff to provide daily skin care. The NCP indicated Resident #1 had "pressure [wound] on her tailbone, wound on her heel and between the knee of the L [left] side." The NCP directed caregivers to turn the resident every two hours and to use two caregivers when providing all transfers and toileting assistance.

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure injury as "localized damage to the skin and/or underlying soft tissue over a bony prominence. Patients are at risk for developing pressure injuries if they have difficulty moving and are unable to easily change position while seated or in bed. However, other contributing factors that increase the risk for a pressure injury would be wrinkled bed sheets, clothing seams and multiple layers of pads."

Record review of Resident #1's chart notes showed Resident #1 was seen by a home health physical therapist from 01/10/19 to 02/05/19, where a turning schedule was given to caregivers for bed positioning to prevent skin breakdown and an informational sheet was given for preventing pressure ulcers in bed and chair. The physical therapist also stated, "Patient has no pressure ulcers." Chart notes showed Resident #1 was seen by a home health nurse beginning on 08/06/19 for multiple wounds and pressure injuries. Home Health notes dated 08/16/19 made the recommendation to the staff to get an order from the medical provider for an alternating pressure mattress. Home health notes dated 10/03/19 showed a request for a physical therapy evaluation for a pressure reducing mattress. The physical therapist saw Resident #1 on 10/07/19 and made the recommendation for a pressure relieving cushion and mattress. Record review of the nurse delegation visit dated 10/09/19, showed Resident #1 had multiple skin breakdowns and the Home Health nurse was managing the wounds.

Observation at 8:35 AM on 10/29/19 showed Resident #1's "Waffle" mattress (inflatable prevention mattress) to be deflated, wrinkled and lying on top of her regular mattress. Staff E (caregiver) was the only caregiver in the home at the time and was unaware of the prevention mattress on Resident #1's bed. At 8:40 AM, Staff B (Resident Manager) arrived from the other AFH next door (AFH License # 750394) to assist Staff B in providing requested documentation from department staff. At 10:11 AM, Staff B was asked if staff had inflated the prevention mattress and Staff B stated Resident #1 did not have a prevention mattress on her bed. When Staff B was shown the deflated mattress, she asked Staff E to get the pump to inflate the mattress. The pump that was found in Resident #1's closet appeared to not work. Staff E went to the other AFH and brought back a pump and attempted to inflate the mattress. The prevention mattress was observed to not hold any air. The staff removed the prevention mattress from the bed.

When interviewed at 8:40 AM on 10/29/19, Staff B stated that Resident #1 was the only two-person transfer in this home and that one caregiver goes between this home and the other home next door (AFH License #750394). AFH License #750394 also had one resident that needed two person assistance.

Record review of Resident #1's Daily Quick Care Chart dated for 10/01/19 showed for the month of October, 13 nights the caregivers marked "N" for "Up at night # of times". The quick chart also showed that Resident #1 slept for an average of 9-11 hours a night. No evidence of a documented turn schedule was found.

When interviewed at 10:02 AM on 10/29/19, Staff D (caregiver) stated that she would document "N" and stated that meant she still turned Resident #1 but Resident #1 would not wake up while being re-positioned.

When interviewed at 3:12 PM on 10/30/19, Collateral Contact #1 (CC) (Home Health Nurse), stated Resident #1 had wounds on her right hip (two open areas), coccyx, left heel, right great toe and a wound behind her left knee. CC #1 also stated that she continued to remind the caregivers that Resident #1 needed to be turned every two hours and to keep areas clean and dry.

Observation at 5:30 AM on 10/31/19 showed only one caregiver (Staff C) was present in the home. When interviewed at 5:48 AM on 10/31/19, Staff C stated that he was unable to change Resident #1's brief or transfer her without the assistance of another caregiver. Staff C stated, "It is not possible- we need two people because of sores and everything." Staff C stated that Staff E (caregiver) helped him turn and provide toileting assistance for Resident #1 every two hours during the night shift.

Observation at 5:30 AM on 10/31/19 by another Department investigator showed that Staff E was working at the AFH next door (License #750394). When interviewed at 5:38 AM on 10/31/19, Staff E stated that he had not provided any care for Resident #1 at any time after 10:00 PM on 10/30/19.

Observation at 6:00 AM on 10/31/19 showed that Resident #1 had an open sore on the top of her right foot that measured approximately two centimeters in diameter. The resident also had a sore between her right great toe and second toe. Resident #1 had bandages on both of her lower extremities and buttock area. There was not an alternating pressure mattress on Resident #1's

bed.

When interviewed again at 6:05 AM on 10/31/19 about who assisted him with Resident #1's care, Staff C stated that it was Staff B (Resident Manager) who helped him during the night (not Staff E as he previously stated). When interviewed at 8:15 AM on 10/31/19, Staff B stated that she was not at the AFH to provide any care for Resident #1.

When interviewed at 6:17 AM on 10/31/19, Staff A (Entity Representative) stated that Staff B left at 11:00 PM last night because of a family emergency, Staff A was scheduled to arrive at 05:00 AM, however Staff A stated that her baby was sick and she arrived at 06:17 AM stating, "I'm here to help Staff C."

Observation at 6:30 AM on 10/31/19 showed Staff A and Staff C changed Resident #1's brief. The task took two caregivers as the resident was resistant during care and had severely contracted lower extremities (a contracture is a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Observation showed that Resident #1's brief appeared to be heavily saturated with urine and dried feces.

Observation at 6:34 AM on 10/31/19 showed while Staff A and Staff C had Resident #1 rolled on her side providing perineal care, Resident #1's right foot was observed rubbing against the wall. The wound on Resident #1's right foot was bleeding as it rubbed against the wall. Staff A and Staff C were not aware of Resident #1's foot rubbing against the wall until Department Staff asked them to protect the foot from rubbing againist the wall.

When interviewed at 9:54 AM on 12/09/19, Staff A stated she could not remember when Resident #1's "Waffle" mattress was purchased and who had ordered it.

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, A BEAUTIFUL PLACE INC is or will be in compliance with this law and / or regulation on (Date) 12/24/19 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Provider (or Representative) 12/24/19 Date

WAC 388-76-10195 Adult family home Staff Generally. The adult family home must ensure:
(1) When one or more residents are in the home, enough staff are available in the home to meet the needs of each resident, except as provided in WAC 388-76-10200 ;

This requirement was not met as evidenced by:
Based on interview, record review and observation, the adult family home (AFH) failed to have enough staff available in the home when one of four residents (Resident #1) needed two staff for

transfers and care needs. This failure resulted in the resident having unmet care needs at night, a decreased quality of life and potentially a delayed evacuation in the event of a fire.

Findings included...

On 10/29/19, review of resident's record revealed Resident #1 was admitted on [redacted]17 with multiple diagnoses including [redacted] and [redacted] Review of Resident #1's assessment dated 12/26/18 showed Resident #1 required two staff to assist with transfers using a [redacted] Resident #1 was incontinent of bowel and bladder, and required two staff to perform all toileting care. Review of Resident #1's negotiated care plan (NCP) dated 08/08/19 indicated Resident #1 had "pressure [wound] on her tailbone, wound on her heel and between the knee of the L [left] side." The NCP directed caregivers to turn the resident every two hours and to use two caregivers when providing all transfers and toileting assistance.

Observation at 8:35 AM on 10/29/19 showed Staff E was the only caregiver in the AFH.

When interviewed at 08:40 AM on 10/29/19, Staff B (Resident Manager) stated that Resident #1 was the only two-person transfer in this home and that one caregiver goes between this home and the other home (AFH License #750394). AFH License #750394 also had one resident that needed two person assistance.

When interviewed at 08:48 AM on 10/29/19, Staff A (Entity Representative) stated they have two caregivers at the AFH and that Staff B was over at the other house next door (AFH License #750394) getting milk when Department staff first arrived.

Observation at 5:30 AM on 10/31/19 showed one caregiver (Staff C) was present in the home. When interviewed at 5:48 AM on 10/31/19, Staff C (caregiver) stated that he was unable to change Resident #1's brief or transfer her without the assistance of another caregiver. Staff C stated, "It is not possible- we need two people because of sores and everything." Staff C stated that Staff E (caregiver) helped him turn and provide toileting assistance for Resident #1 every two hours during the night shift.

Observation at 5:30 AM on 10/31/19 by another Department investigator showed that Staff E was working at the AFH next door (AFH License #750394). When interviewed at 5:38 AM on 10/31/19, Staff E stated that he had not provided any care for Resident #1 at any time after 10:00 PM on 10/30/19.

When interviewed again at 6:05 AM on 10/31/19 about who assisted him with Resident #1's care, Staff C stated that it was Staff B (Resident Manager) who helped him during the night (not Staff E as he previously stated). When interviewed at 8:15 AM on 10/31/19, Staff B stated that she was not at the AFH to provide any care for Resident #1.

When interviewed at 06:17 AM on 10/31/19, Staff A stated Staff B left at 11:00 PM last night because of a family emergency, Staff A was scheduled to arrive at 05:00 AM, however her baby was sick and she arrived at 06:17 AM stating, "I'm here to help Staff C."

When interviewed at 7:05 AM on 10/31/19, Staff A was asked how she would evacuate the AFH with one caregiver. Staff A stated that she would start with the resident's that were ambulatory

and then the residents that needed assistance including Resident #1. Staff A stated she would have to get Resident #1 to the floor and drag her out on a sheet.

When interviewed at 07:25 AM on 10/31/19, Staff F (the Entity Representative at AFH License #750394), stated that he had misspoke the other day when he stated they had two caregivers working 24/7. He stated, "that was incorrect."

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, A BEAUTIFUL PLACE INC is or will be in compliance with this law and / or regulation on (Date) 12/24/19 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Provider (or Representative)

12/24/19
Date