



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

October 28, 2019

Lena's Gentle Care Inc
Lena's Gentle Care Inc
9706 E Morgan Rd
Spokane, WA 99217

RE: Lena's Gentle Care Inc License #753078

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on October 23, 2019 for the deficiency or deficiencies cited in the report/s dated September 24, 2019 and found no deficiencies.

The Department staff who did the inspection:
Brian Zbylski, NCI/Community Complaint Investigator

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

Sincerely,

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



**Residential Care Services
Investigation Summary Report**

Provider/Facility: Lena's Gentle Care Inc (949774) **Intake ID(s):** 3663834

License/Cert. #: AF753078

Investigator: Zbyski, Brian **Region/Unit:** RCS Region 1/Unit B **Investigation Date(s):** 09/11/2019 through 09/12/2019

Complainant Contact Date(s):

Allegations:

1. A named resident had wandered away from the home during the night.
-

Investigation Methods:

Sample: Four residents.

Observations: Staff presence and availability to residents. Facility and facility premises security measures. Motion sensors on premises. Resident rooms. Resident mobility in the setting.

Interviews: One resident. Provider. Caregiver.

Record Reviews: Resident assessments, care plans, notes. Incident log. Resident prescription orders.

Allegation Summary:

1. A named resident wandered away from the premises during the night. The staff was alerted to the missing resident by local law enforcement. The home did not have measures in place to ensure the resident's safety, who had a history exit seeking behavior. Deficient practice identified.
-

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



Residential Care Services
Investigation Summary Report

Conclusion / **Failed Provider Practice Identified /**
Action: **Citation(s) Written**

Failed Provider Practice Not Identified /
No Citation Written

The deficient practice was documented in the Statement of Deficiencies dated 09/17/2019:
Washington Administrative Code (WAC) 388-76-10400(3)(a) Care and services



RECEIVED

OCT 02 2019

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

Statement of Deficiencies License #: 753078 Completion Date
Plan of Correction Lena's Gentle Care Inc September 24, 2019
Page 1 of 3 Licensee: Lena's Gentle Care 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: 9/11/2019

Lena's Gentle Care Inc
9706 E Morgan Rd
Spokane, WA 99217

This document references the following complaint number: 3663834

The department staff that inspected and investigated the adult family home:
Brian Zbyski, RN, BSN, NCI/Community Complaint Investigator

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)323-7324

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

9/25/19
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.

X 
Provider (or Representative)

X 9/29/19
Date

This document was prepared by Residential Care Services for the Locator website.

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 home failed to ensure the safety of one of three residents (#6) reviewed for wandering in a sample of six. The failed practice placed residents at risk of injury in the event they left the home without staff knowledge.

Findings included...

In an interview with Staff C, Provider, on 09/11/19 at 10:15 AM, she stated that about one month prior, Resident #6 wandered off the premises during the night and she was alerted by local law enforcement who found the resident walking down the road dressed only in an incontinent brief. Staff C stated that she was in charge of the residents at the time, was the only staff member working, and was taking a shower when the resident walked away.

Review of staff notes dated 08/13/19, showed that Resident #6 was seen by Staff C in his bedroom at 11:15 PM. The notes also showed that Staff C received a phone call from the police at 1:00 AM notifying her that the resident was found about 500 feet from the home.

On 09/11/19, review of Resident #6's negotiated care plan dated 07/15/19, showed that the resident had a history of exit seeking behavior and staff were to keep a Global Positioning System (GPS) monitor on the resident 24 hours a day.

In an interview with Staff C on 09/11/19 at 12:30 PM, she stated that Resident #6 refused to wear his GPS monitor and had thrown it in the trash or toilet on multiple occasions. During the interview, the GPS monitor belonging to the resident was in the business office and was shown to the investigator by Staff C.

In a telephone interview with Staff C on 09/12/19 at 9:05 AM, she stated that she was aware that Resident #6 had a history of wandering. When Staff C was asked by the investigator how the staff monitored the resident after he refused to wear his GPS, she replied "just watch him." She stated that nighttime staff "always" hear the door chime but she did not hear it on the night of the incident because she was taking a shower.

In a telephone interview with Resident #6 on 09/24/19 at 12:35 PM, the resident stated that he did not remember walking away from the home during the early morning of 08/14/19. The resident was unable to recall any details from the incident.

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, Lena's Gentle Care Inc is or will be in compliance with this law and / or regulation on (Date) 9/29/19. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

X LL Lindeef
Provider (or Representative)

X 9/29/19
Date