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

LISA ANDERSON
JOSHUAS HOUSE
1809 TOWNSHIP ST
SEDRO WOOLLEY, WA 98284

RE: JOSHUAS HOUSE License # 750071

Dear Provider:

This letter addresses Compliance Determination(s) 38081 (Completion Date 03/11/2024) and 34889 (Completion Date 01/24/2024).

The Department completed a follow-up inspection of your Adult Family Home on 03/11/2024 and found that you have corrected the violations listed in the Complaint report dated 01/24/2024. Your home is back in compliance as of 02/10/2024 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10250-1, WAC 388-76-10225-2-b, WAC 388-76-10225-2-c

The Department staff who did the on-site verification:
Jennifer Nichols, Community Complaint Investigator

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn, Field Manager
Region 2, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: JOSHUAS HOUSE
Provider Type: Adult Family Home
License/Cert.#: 750071
Compliance Determination #: 34889
Intake ID: 112880
Investigator: Jennifer Nichols
Region/Unit #: RCS Region 2 / Unit B
Investigation Date(s): 01/08/2024 through 01/24/2024
Complainant Contact Date(s): 01/05/2024, 01/23/2024

Allegation(s):

1) The named resident had an injury related fall that required staples.
2) The named Adult Family Home (AFH) staff member did not clean the named resident's bleeding injury.
3) The AFH did not notify the responsible party of the named resident when the named resident fell.
4) The AFH did not obtain medical attention for the named resident's injury.
5) The AFH did not do an incident report for the named resident's fall.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 2 Closed records sample size: 0
Observations:	Residents Activities Resident rooms Staff to resident interactions Kitchen
Interviews:	Nursing staff Residents Resident representative
Record Reviews:	Medical records State reporting log Facility policies

Investigation Summary:

1) The named resident's record review showed they did have a fall resulting in an injury. The AFH logged the incident and notified the named resident's responsible party. Record review showed the named resident was treated at the local hospital and received staples to close the head wound.
2) Record review showed AFH staff cleaned the named resident's bleeding head injury. AFH staff reported they cleaned the named resident's bleeding head injury.
3) The named resident's responsible party reported they were notified 15 hours after the named resident's bleeding head injury occurred. Record review showed the AFH did

not notify the named resident's family or health care provider. There was no documentation to show that notifications were made regarding the named resident's fall and related injury immediately after it occurred.
4) Record review showed the AFH did not obtain medical treatment for the named resident's bleeding head injury.
5) The AFH logged the named resident's fall with injury incident as required.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Statement of Deficiencies	License #: 750071	Compliance Determination # 34889
Plan of Correction	JOSHUAS HOUSE	Completion Date
Page 1 of 5	Licensee: LISA ANDERSON	01/24/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 01/08/2024 and 01/08/2024 of:

JOSHUAS HOUSE
1809 TOWNSHIP ST
SEDRO WOOLLEY, WA 98284

This document references the following complaint number(s): 112880

The following sample was selected for review during the unannounced on-site visit: 2 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

As a result of the on-site visit(s), 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.

nflynn
Residential Care Services

01/31/2024
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 388-76-10250 Medical emergencies Contacting emergency medical services Required.

(1) The adult family home must develop and implement policies and procedures which require immediate contact of the local emergency medical services when a resident has a medical emergency. This requirement applies:

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to implement their policy that required immediate contact of the local emergency medical services when 1 of 5 residents (Resident 1) had a fall with a bleeding injury to their head that required staples to treat. This failure resulted in delayed medical intervention for Resident 1's head injury.

Findings included..

Record review of the AFH's Policy on Contacting Emergency Medical Services, signed and dated by Resident 1 on 02/01/2023, showed AFH staff was to call 911 for major emergencies.

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with diagnoses that included [redacted] and a history of falls. Resident 1's Negotiated Care Plan, dated 01/20/2023, showed Resident 1 required caregiver assistance with activities of daily living.

Record review of the AFH's incident log, dated 12/30/2023 at 4:00 AM, showed Staff A (Caregiver) found Resident 1 on the floor with a bleeding injury to their head. The incident log showed Staff A cleaned the blood off Resident 1's head and assisted Resident 1 back to bed. The incident log did not show any documentation that AFH Staff notified local emergency medical services, Resident 1's health care provider, or Resident 1's representative.

In an interview, on 01/05/2024 at 2:32 PM, Collateral Contact 1 (CC1) reported that Resident 1's friend visited the AFH on 12/30/2023 and noticed the injury to Resident 1's head. CC1 stated they took Resident 1 to the hospital in the afternoon on 12/30/2023 to get Resident 1's bleeding head injury treated.

Record review of Resident 1's hospital After Visit Summary (AVS), dated 12/30/2023, showed Resident 1 received head, spine, and shoulder imaging at the hospital. Resident 1's hospital AVS showed Resident 1 required staples to close the head wound.

In an interview, on 01/18/2024 at 3:02 PM, Collateral Contact 2 (CC2) reported the AFH notified them at 7:00 PM on 12/30/2023 that Resident 1 had a bleeding injury to the head that required staples from the hospital. CC2 reported that the AFH did not tell CC2 why they did not immediately contact the local emergency medical services for Resident 1's bleeding head injury.

In an interview, on 01/18/2024 at 8:15 PM, Staff A reported they did not immediately contact local emergency medical services when they found Resident 1 on the floor with a bleeding head injury, on 12/30/2024 at 4:00 AM, because they thought Resident 1's bleeding head injury was not very big and thought the bleeding had stopped.

Record review of an email sent to the Department, on 01/19/2024, Staff B (Provider) reported that they believed Resident 1's bleeding head injury was small like the size of "the tip of a black sharpie" and felt that Resident 1 may have done something to make their bleeding head injury bigger.

In an interview, on 01/24/2024 at 1:30 PM, Staff B stated that they "had no answer" for why AFH Staff did not immediately contact local emergency medical services for Resident 1's bleeding head injury.

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, JOSHUAS HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/16/24.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) Lisa Anderson Date 2/9/2024

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(b) The resident's representative, if one exists;

(c) The resident's health care provider;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to immediately notify a resident's health care provider and representative of a bleeding injury to the head that required staples for 1 of 5 residents (Resident 1). This failure resulted in delayed medical intervention for Resident 1's head injury.

Findings included...

Record review showed the AFH admitted Resident 1 on [redacted]/2023 with diagnoses that included [redacted] and a history of falls. Resident 1's Negotiated Care Plan, dated 01/20/2023, showed Resident 1 required caregiver assistance with activities of daily living.

Record review of the AFH's incident log, dated 12/30/2023 at 4:00 AM, showed Staff A (Caregiver) found Resident 1 on the floor with a bleeding injury to their head. The incident log showed Staff A cleaned the blood off Resident 1's head and assisted Resident 1 back to bed. The incident log did not show any documentation that AFH Staff notified local emergency medical services, Resident 1's health care provider, or Resident 1's representative.

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Record review of Resident 1's hospital After Visit Summary (AVS), dated 12/30/2023, showed Resident 1 received head, spine, and shoulder imaging at the hospital. Resident 1's hospital AVS showed Resident 1 required staples for their bleeding head injury.

In an interview, on 01/18/2024 at 3:02 PM, Collateral Contact 2 (CC2) reported the AFH notified them at 7:00 PM on 12/30/2023 that Resident 1 had a bleeding injury to the head that required staples from the hospital. The AFH notified CC2 of Resident 1's injury 15 hours after it occurred.

In an interview, on 01/24/2024 at 1:30 PM, Staff B (Provider) stated that they were not notified of Resident 1's bleeding head injury until the evening of 12/30/2023 and that AFH Staff made a mistake in not immediately notifying the required parties for Resident 1's injury.

This is a repeated deficiency previously cited on 06/25/2021 for subsection 2-c only.

Attestation Statement

Statement of Deficiencies	License #: 750071	Compliance Determination # 34889
Plan of Correction	JOSHUAS HOUSE	Completion Date
Page 5 of 5	Licensee: LISA ANDERSON	01/24/2024

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, JOSHUAS HOUSE is or will be in compliance with this law and / or regulation on (Date) 2/10/24 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Lisa Anderson — Provider (or Representative)

2/9/24 — Date