STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
6639 Capitol Blvd SW, Floor 1, Tumwater, WA 98501

Phyllis Cares Adult Family Home One LLC

Phyllis Cares Adult Family Home One LLC
7626 97th Ave SW
Lakewood, WA 98498

RE: Phyllis Cares Adult Family Home One LLC License # 756548

Dear Provider:

This letter addresses Compliance Determination(s) 41630 (Completion Date 05/23/2024) and 33987 (Completion Date 04/04/2024).

The Department completed a follow-up inspection of your Adult Family Home on 05/23/2024 and found that you have corrected the violations listed in the Complaint report dated 04/04/2024. Your home is back in compliance as of 04/11/2024 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 388-76-10220-3, WAC 388-76-10355-1, WAC 388-76-10355-2, WAC 388-76-10355-3, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10225-2-f

The Department staff who did the on-site verification:
Alexander Ulbrickson, NCI AFH Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Phyllis Cares Adult Family Home One LLC
Provider Type: Adult Family Home
License/Cert.#: 756548
Intake ID: 110468
Compliance Determination #: 33987
Region/Unit #: RCS Region 3 / Unit G
Investigator: Alexander Ulbrickson
Investigation Date(s): 12/15/2023 through 04/04/2024
Complainant Contact Date(s): 04/04/2024, 12/15/2023

Allegation(s):

1. Resident/Patient/Client Neglect - The adult family home (AFH) did not call emergency medical services (EMS) in a timely manner and the Named Resident (NR) was found to have a very low blood pressure and was unresponsive. The NR was covered in feces and had multiple pressure injuries.

2. Injury of Unknown Origin - The NR had red marks on their pelvis and private area.

Investigation Methods:

Sample:	Total residents: 3 Resident sample size: 3 Closed records sample size: 0
Observations:	Environment, care and services, staff interaction with residents.
Interviews:	NR, Two Other Residents (OR), AFH Provider, AFH staff, others not associated with the AFH.
Record Reviews:	Assessments, negotiated care plans (NCP), progress notes, incident log, medication administration records (MAR), medical records.

Investigation Summary:

1. Resident/Patient/Client Neglect - The AFH Provider and staff stated the NR had diarrhea prior to being taken to the hospital and they had attempted to clean them up. The NR had multiple pressure injuries on their body. The NR stated they didn't think that the AFH took care of them. The NR stated they did not have skin issues prior to admission to the AFH. The NR's hospital records prior to admission to the AFH showed they did not have any skin issues. The NR's assessment prior to admission to the AFH showed they had no skin issues. The NR's NCP did not have any skin concerns listed. The AFH Provider stated they had notified NR's physician about their skin concerns and had called them when they had a change of condition. The AFH did not notify the NR's department case manager of a change in condition for the NR's skin issues or create an incident log for this. Failed practice was identified.

2. Injury of Unknown Origin - The NR had multiple pressure injuries on their body. The NR stated they didn't think the AFH took care of them. The NR's NCP did not have any skin concerns listed. The AFH incident logs did not include any entries for NR's skin injuries. The AFH did not notify the NR's department case manager of any changes in condition. Failed practice was identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Phyllis Cares Adult Family Home One LLC
Provider Type: Adult Family Home
License/Cert.#: 756548
Intake ID: 111024
Compliance Determination #: 33987
Region/Unit #: RCS Region 3 / Unit G
Investigator: Alexander Ulbrickson
Investigation Date(s): 12/15/2023 through 04/04/2024
Complainant Contact Date(s): 04/04/2024

Allegation(s):

1. Resident/Patient/Client Neglect - The Named Resident (NR) was found to have a very low blood pressure and was unresponsive. The NR was covered in feces and had multiple pressure injuries.

2. Resident/Patient/Client Assessment - The adult family home (AFH) did not call emergency medical services (EMS) in a timely manner.

Investigation Methods:

Sample:	Total residents: 3 Resident sample size: 3 Closed records sample size: 0
Observations:	Environment, care and services, staff interaction with residents.
Interviews:	NR, Two Other Residents (OR), AFH Provider, AFH staff, others not associated with the AFH.
Record Reviews:	Assessments, negotiated care plans (NCP), progress notes, incident log, medication administration records (MAR), medical records.

Investigation Summary:

1. Resident/Patient/Client Neglect - The AFH Provider and staff stated the NR had diarrhea prior to being taken to the hospital and they had attempted to clean them up. The NR had multiple pressure injuries on their body. The NR stated they didn't think that the AFH took care of them. The NR stated they did not have skin issues prior to admission to the AFH. The NR's assessment prior to admission to the AFH showed they had no skin issues. The NR's hospital records prior to admission to the AFH showed they had no skin issues. The NR's NCP did not have any skin concerns listed. The AFH Provider stated they had notified NR's physician about their skin concerns and had called them when they had a change of condition. Failed practice was identified.

2. Resident/Patient/Client Assessment - The AFH called EMS after they attempted to call the NR's physician. The AFH Provider stated the NR had skin issues since they took

over the AFH. The NR's assessments showed they had no skin issues prior to admission to the AFH. The NR's hospital records prior to admission to the AFH showed they had no skin issues. The AFH did not create an incident log for the NR's skin concerns or notify their department case manager of changes of condition for the NR's skin. The AFH did not include any skin concerns on the NR's NCP. Failed practice was identified.

Conclusion / Action:

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

6639 Capitol Blvd SW, Floor 1, Tumwater, WA 98501

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 12/15/2023 and 04/04/2024 of:

Phyllis Cares Adult Family Home One LLC
7626 97th Ave SW
Lakewood, WA 98498

This document references the following complaint number(s): 110468, 111024

The following sample was selected for review during the unannounced on-site visit: 3 of 3 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Alexander Ulbrickson, NCI AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit G
6639 Capitol Blvd SW, Floor 1
Tumwater, WA 98501

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.

Jennifer LeMaster
Residential Care Services

04/05/2024
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 388-76-10220 Incident log. The adult family home must keep a log of:

(3) Any injury to a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure that an incident log was created for an injury for 1 out of 3 residents (Resident 1 [R1]). This failure resulted in R1 having multiple skin injuries that were not documented on an incident log and prevented the AFH from tracking patterns and developing interventions to prevent future injuries to R1.

Findings included...

Record review of R1's assessment, dated 07/19/2023, showed that their skin was intact over all pressure points and they had no current pressure injuries or other skin concerns. The assessment showed R1 did not have any skin injuries that had been resolved or cured in the past year.

Record review of R1's Negotiated Care Plan (NCP) dated 07/01/2023 showed there were no skin concerns listed under their current medical status. The NCP showed R1 did not have any skin issues due to their inability to position themselves. The NCP showed R1 did not have any skin problems or dressing changes and they were to receive skin care from AFH caregivers.

Record review of hospital records dated [redacted]/2023 showed R1 was admitted to the hospital on [redacted]2023 for diagnoses including [redacted] and [redacted]

On 12/15/2023 at 3:40 PM, the AFH Provider stated that R1 had skin issues since they had taken over the ownership of the AFH in August 2023. The AFH Provider stated that R1's physician was aware of their ongoing skin issues.

Record review of R1's hospital records dated [redacted]2023 showed they arrived at the hospital on [redacted]2023 with multiple pressure wounds. The hospital records showed that R1 had a pressure injury to their right outer ankle that was 3.5 centimeters (cm) in diameter, with dead tissue and that extended into the fat layer and possibly to the bone. The wound was described as having surrounding redness and a foul odor. The hospital records showed R1 had scabs on their right third and fourth toes and on the second left

toe. The hospital records showed R1 had a pressure injury to their left heel that was 1 cm in diameter and a 1 cm scab to their outer left foot. The hospital records showed that R1's lower back and buttocks area was covered with feces and that there was skin breakdown around their anus. The hospital records showed that R1 had a stage 2 or 3 pressure injury to their sacrum (area located at the base of the spine) the size of a quarter.

Record review of an AFH Incident Log dated [redacted]/2023 showed AFH staff called 911 for R1 when they appeared disoriented and were not responding like normal. There were no other entries for R1 related to any skin injuries or wounds.

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, Phyllis Cares Adult Family Home One LLC is or will be in compliance with this law and / or regulation on (Date) 04/11/2024

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

e Saffirm — Provider (or Representative)

04/11/24 — Date

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure the Negotiated Care Plan (NCP) included a complete list of care and services to be provided, the identification of who would provide the care and services, and when and how care and services would be provided for 1 of 3 residents (Resident 1 [R1]). This failure resulted in R1 not receiving interventions for newly identified skin injuries and prevented the necessary care planning to prevent them from requiring hospitalization for treatment of their medical needs.

Findings included...

Record review of R1's assessment, dated 07/19/2023, showed that their skin was intact over all pressure points and they had no current pressure injuries or other skin concerns.

The assessment showed R1 did not have any skin injuries that had been resolved or cured in the past year. The assessment showed R1 used a wheelchair for ambulation and required the assistance of two people for turning and transferring. The assessment showed R1 was incontinent of bowel and bladder and required assistance to clean themselves.

On 12/15/2023 at 2:49 PM a review of R1's negotiated care plan (NCP), dated 07/01/2023, showed there were no skin concerns listed under their current medical status. The NCP showed R1 did not have any skin issues due to their inability to position themselves. The NCP showed R1 did not have any skin problems or dressing changes and they were to receive skin care from AFH caregivers. No individuals were identified as being involved in any wounds or wound care for R1. No documentation of any wounds was in the NCP.

Record review of hospital records dated [redacted]/2023 showed R1 was admitted to the hospital on [redacted]2023 for diagnoses including [redacted] and [redacted].

On 12/15/2023 at 3:40 PM, the AFH Provider stated that R1 had skin issues since they had taken over the ownership of the AFH in August 2023. The AFH Provider stated that R1's physician was aware of their ongoing skin issues.

Record review of R1's hospital records dated [redacted]/2023 showed they arrived at the hospital on [redacted]/2023 with multiple pressure wounds. The hospital records showed that R1 had a pressure injury to their right outer ankle that was 3.5 centimeters (cm) in diameter, with dead tissue and that extended into the fat layer and possibly to the bone. The wound was described as having surrounding redness and a foul odor. The hospital records showed R1 had scabs on their right third and fourth toes and on the second left toe. The hospital records showed R1 had a pressure injury to their left heel that was 1 cm in diameter and a 1 cm scab to their outer left foot. The hospital records showed that R1's lower back and buttocks area was covered with feces and that there was skin breakdown around their anus. The hospital records showed that R1 had a stage 2 or 3 pressure injury to their sacrum (area located at the base of the spine) the size of a quarter.

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, Phyllis Cares Adult Family Home One LLC is or will be in compliance with this law and / or regulation on (Date) 04/11/2024.

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

[signature] 04/11/2024

Provider (or Representative) 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:

(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 interview and record review, the adult family home (AFH) failed to ensure that 1 of 3 residents (Resident 1 [R1]) received care and services in a manner that actively supported, maintained, or improved their quality of life and actively supported their safety. This failure resulted in R1 requiring care at the hospital for wounds that developed while living at the AFH.

Findings included...

Record review of R1's hospital records dated from 04/01/2023 to 04/20/2023 showed they had no skin concerns or diagnoses.

Record review of R1's assessment, dated 07/19/2023, showed that their skin was intact over all pressure points and they had no current pressure injuries or other skin concerns. The assessment showed R1 did not have any skin injuries that had been resolved or cured in the past year. The assessment showed R1 used a wheelchair for ambulation and required the assistance of two people for turning and transferring. The assessment showed R1 was incontinent of bowel and bladder and required assistance to clean themselves.

Record review of R1's Negotiated Care Plan (NCP) dated 07/01/2023 showed there were no skin concerns listed under their current medical status. The NCP showed R1 did not have any skin issues due to their inability to position themselves. The NCP showed R1 did not have any skin problems or dressing changes and they were to receive skin care from AFH caregivers.

Record review of department records showed the AFH underwent a change of ownership on 08/07/2023.

Record review of an AFH Incident Log dated [redacted]/2023 showed AFH staff called 911 for R1 when they appeared disoriented and were not responding like normal.

Record review of hospital records dated [redacted]/2023 showed R1 was admitted to the hospital on 12/14/2023 for diagnoses including [redacted] and [redacted].

On 12/15/2023 at 3:40 PM, the AFH Provider stated that R1 had skin issues since they had taken over the ownership of the AFH in August 2023. The AFH Provider stated that R1's physician was aware of their ongoing skin issues.

On 12/15/2023 at 3:40 PM, Caregiver 1 (CG1) stated R1 had a foot wound that was usually dry and that they had not done anything for it since they had been at the AFH. CG1 stated that when R1 required transport to the hospital on [redacted]/2023, the foot wound had opened. CG1 stated that R1's buttocks were "raw" when they went to the hospital on [redacted]/2023.

On 12/15/2023 at 3:45 PM, CG1 provided a copy of an undated photo of R1's foot wound which they stated they had sent to R1's physician. The photo showed a wound on the lateral side of R1's right ankle with fatty tissue visible.

On 12/20/2023 at 11:02 AM, the AFH Provider emailed to the department a visitor's log dated 10/30/2023 that showed R1's healthcare provider had visited the AFH. The AFH Provider stated in their email to the department that the purpose of the 10/30/2023 visit for R1 was to assess R1's condition, but the primary concern for the visit was about R1 having diarrhea.

Record review of R1's hospital records dated [redacted]/2023 showed they arrived at the hospital on [redacted]/2023 with multiple pressure wounds. The hospital records showed that R1 had a pressure injury to their right outer ankle that was 3.5 centimeters (cm) in diameter, with dead tissue and that extended into the fat layer and possibly to the bone. The wound was described as having surrounding redness and a foul odor. The hospital records showed R1 had scabs on their right third and fourth toes and on the second left toe. The hospital records showed R1 had a pressure injury to their left heel that was 1 cm in diameter and a 1 cm scab to their outer left foot. The hospital records showed that R1's lower back and buttocks area was covered with feces and that there was skin breakdown around their anus. The hospital records showed that R1 had a stage 2 or 3 pressure injury to their sacrum (area located at the base of the spine) the size of a quarter. The hospital records showed R1 was treated for septic shock and required multiple antibiotic medications for treatment.

On 01/31/2024 at 2:10 PM, R1 stated they had not been taken care of at the AFH and had ended up with a bone infection in a wound on their foot. R1 stated they were not assisted with turning or toileting often and there was usually only 1 caregiver at the AFH. R1 stated AFH staff didn't help them turn. R1 denied having any skin concerns prior to being admitted to the AFH. R1 stated they received medical attention for their skin once they had gone to the hospital. R1 stated they saw a doctor every month at the AFH, but they didn't look at their skin. R1 stated they had received their wounds at the AFH and didn't think AFH staff had told the doctor about their skin issues.

On 02/01/2024 at 1:11 PM, Collateral Contact 1 (CC1) stated they had looked back over R1's prior assessments and R1 had denied having any skin issues for the assessment that

was done prior to their admission to the AFH. CC1 stated that R1 had a higher risk of skin issues and that this information was put into their assessment, along with information about frequent turning and daily skin checks. CC1 stated the AFH never reached out to them about any skin issues or wounds. CC1 stated they had not known the seriousness of R1's condition and had heard about it from the hospital, not the AFH.

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, Phyllis Cares Adult Family Home One LLC is or will be in compliance with this law and / or regulation on (Date) 04/11/2024 .

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

Provider (or Representative) ..... Date 04/11/2024

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:

(f) The resident's case manager if the resident is a department client.

This requirement was not met as evidenced by:

Based on interview and record review the adult family home (AFH) failed to notify the department case manager for 1 out of 3 residents (Resident 1 [R1]) of a significant change in their condition. This failure resulted in a delay in R1's case manager being aware of new skin injuries.

Findings included...

Record review of R1's assessment, dated 07/19/2023, showed that their skin was intact over all pressure points and they had no current pressure injuries or other skin concerns. The assessment showed R1 did not have any skin injuries that had been resolved or cured in the past year.

Record review of R1's Negotiated Care Plan (NCP) dated 07/01/2023 showed there were no skin concerns listed under their current medical status. The NCP showed R1 did not have any skin issues due to their inability to position themselves. The NCP showed R1 did not have any skin problems or dressing changes and they were to receive skin care from AFH caregivers.

Record review of hospital records dated [redacted] 2023 showed R1 was admitted to the hospital on [redacted] 2023 for diagnoses including [redacted] and [redacted]

On 12/15/2023 at 3:40 PM, the AFH Provider stated that R1 had skin issues since they had taken over the ownership of the AFH in August 2023. The AFH Provider stated that R1's physician was aware of their ongoing skin issues.

Record review of R1's hospital records dated [redacted] 2023 showed they arrived at the hospital on [redacted] 2023 with multiple pressure wounds. The hospital records showed that R1 had a pressure injury to their right outer ankle that was 3.5 centimeters (cm) in diameter, with dead tissue and that extended into the fat layer and possibly to the bone. The wound was described as having surrounding redness and a foul odor. The hospital records showed R1 had scabs on their right third and fourth toes and on the second left toe. The hospital records showed R1 had a pressure injury to their left heel that was 1 cm in diameter and a 1 cm scab to their outer left foot. The hospital records showed that R1's lower back and buttocks area was covered with feces and that there was skin breakdown around their anus. The hospital records showed that R1 had a stage 2 or 3 pressure injury to their sacrum (area located at the base of the spine) the size of a quarter.

On 02/01/2024 at 1:11 PM Collateral Contact 1 (CC1) stated the AFH had never reached out to them about any skin issues or wounds. CC1 stated they had not known the seriousness of R1's condition and had heard about it from the hospital, not the AFH.

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, Phyllis Cares Adult Family Home One LLC is or will be in compliance with this law and / or regulation on (Date) 04/11/2024

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

Provider (or Representative) _____ Date 04/11/2024