



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

August 1, 2016

Amor H Youngs  
MAGNOLIA HOME CARE  
3223 - 12th Ave West  
SEATTLE, WA 98119

RE: MAGNOLIA HOME CARE License #479800

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on July 27, 2016 for the deficiency or deficiencies cited in the report/s dated June 6, 2016 and found no deficiencies.

The Department staff who did the inspection:  
Brenda Mooney, Licensor

If you have any questions please, contact me at (253) 234-6033.

Sincerely,

Bennetta Shoop, Field Manager  
Region 2, Unit E  
Residential Care Services



**Residential Care Services  
Investigation Summary Report**

**Provider/Facility:** MAGNOLIA HOME CARE (687013)      **Intake ID(s):** 3227888

**License/Cert. #:** AF479800

**Investigator:** Johnson, Shauna      **Region/Unit:** RCS Region 2/Unit D

**Investigation Date(s):** 05/25/2016 through 06/06/2016

**Complainant Contact Date(s):** 05/24/2016, 05/26/2016, 05/27/2016

**Allegations:**

It was reported the named resident appeared with bruises on [redacted] face, forehead, nose, black eyes and had a [redacted] tied around [redacted] waist to the back of a chair.

**Investigation Methods:**

**Sample:** 3 of 5 Residents. Named Resident included

**Observations:** General resident appearance, hygiene, limited skin observations, staff to resident care and interactions, [redacted] assistive devices, [redacted]

**Interviews:** Residents, staff, others not associated with facility

**Record Reviews:** Resident records, accident log, abuse policy, staff files, staff training

**Allegation Summary:**

Based on observations, interviews and record review, failed practice was identified when one resident was observed seated in a [redacted] with a [redacted] around [redacted] waist buckled in the back. This failure placed this resident at risk of physical restraint, emotional harm. There was no information documented on the care plan regarding the use of the [redacted]. The named resident also had signs of bruises (slight, faint, yellowish) on [redacted] forehead and also underneath [redacted] eyes; [redacted] did not answer questions. Staff reported the named resident had a fall history and recent fall (05/21/16). Staff verbalized AFH policy, procedure for resident fall, accident including contacting family, MD and hotline as mandated reporters. Staff also verbalized examples of physical, verbal abuse. Other residents appeared in no distress.

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



**Residential Care Services  
Investigation Summary Report**

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

**Failed Provider Practice Not Identified / No Citation Written**

See SOD 06/06/16. WAC 388-76-10655 Physical restraints



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Statement of Deficiencies	License #: 479800	Completion Date
Plan of Correction	MAGNOLIA HOME CARE	June 6, 2016
Page 1 of 3	Licensee: Amor H. Youngs	

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.

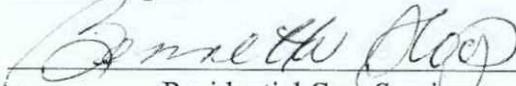
The department has completed data collection for the unannounced on-site complaint investigation of: 5/25/2016  
 MAGNOLIA HOME CARE  
 2670 37TH AVE W  
 SEATTLE, WA 98199

This document references the following complaint number: 3227888  
 The department staff that inspected and investigated the adult family home:  
 Shauna Johnson, RN, MSN, Complaint Investigator

From:  
 DSHS, Aging and Long-Term Support Administration  
 Residential Care Services, Region 2, Unit E  
 20425 72nd Avenue S, Suite 400  
 Kent, WA 98032-2388  
 (253)234-6033

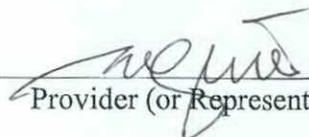
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As a result of the on-site complaint investigation the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

  
 Residential Care Services

06/14/2016  
 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)

6/21/16  
 Date

**WAC 388-76-10655 Physical restraints. The adult family home must ensure:**

- (1) Each resident's right to be free from physical restraints used for discipline or convenience;
- (2) Less restrictive alternatives have been tried;
- (3) That physical restraints used have been assessed as necessary to treat the resident's medical symptoms; and
- (4) That if physical restraints are used to treat a resident's medical symptoms that the restraints are applied and immediately supervised on-site by a:
  - (a) Licensed registered nurse;
  - (b) Licensed practical nurse; or
  - (c) Licensed physician; and
  - (d) For the purposes of this subsection, immediate supervised means that the licensed person is in the home and quickly and easily available.
- (1) Each resident's right to be free from physical restraints used for discipline or convenience;
- (2) Less restrictive alternatives have been tried;
- (3) That physical restraints used have been assessed as necessary to treat the resident's medical symptoms; and
- (4) That if physical restraints are used to treat a resident's medical symptoms that the restraints are applied and immediately supervised on-site by a:
  - (a) Licensed registered nurse;
  - (b) Licensed practical nurse; or
  - (c) Licensed physician; and
  - (d) For the purposes of this subsection, immediate supervised means that the licensed person is in the home and quickly and easily available.

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

Based on observations, interviews and record review, the adult family (AFH) failed to ensure one of one resident (Resident #1) was free from restraint not assessed as necessary to treat medical symptoms. The AFH used a [REDACTED] to place around Resident #1's waist to [REDACTED] which restricted [REDACTED] from getting up while [REDACTED] was seated in the [REDACTED]. This failure placed Resident #1 at risk of physical restraint and emotional harm. Findings include:

Observations, interviews and record review took place 05/25/16 unless otherwise noted.

WAC 388-75-100 Definition: "Physical restraints means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and is not required to treat the resident's medical symptoms."

Observations on 05/25/16 at approximately 4:30 p.m., noted 2 of 5 residents (Residents #1, #3) seated at a table in the dining area near the kitchen. There were 2 residents (Residents #2, #5) sitting in the nearby living room eating their dinner. Two staff were on duty (Staff A, B) and notified the Provider and Staff C. Resident #1 was quiet, and did not answer questions when the investigator asked how [REDACTED] was doing. Resident #1 was observed sitting in [REDACTED] with a [REDACTED] placed around [REDACTED] waist and buckled in the back of the [REDACTED]. The investigator asked Staff A about the [REDACTED] and how long Resident #1 had been sitting there. Staff A said "about 5 - 10 minutes that he was preparing dinner...." Staff A stated Resident #1

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"slipped" out of the [redacted] sometimes and the belt was, "It's safety for the patient..." Further, Staff A told the investigator, "It's prohibited, against the rules..." Staff A and B were asked about the [redacted] and they stated the [redacted] was used to assist during care and transfers of residents. Staff B demonstrated the use of the [redacted] with Resident #1 as she had the resident stand up and "readjust" [redacted]

Record review noted Resident #1 was admitted to the AFH [redacted] 16 for multiple medical conditions which included [redacted] Resident #1 was also receiving [redacted] Resident #1's Assessment/Negotiated Care Plan, (Page 5) noted she was a fall risk, history of [redacted] and "had a history of falls which had caused [redacted] lacks safety awareness...would try to get out of bed... sometimes can coherently answer questions, may also sometimes make needs known but frequently caregivers need to anticipate [redacted] needs...is forgetful and confused..." Page 11, "Ambulates with [redacted] with one person standby assist and needs [redacted] There was no information regarding a [redacted]

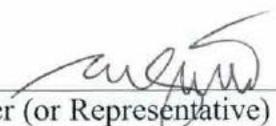
In a 05/31/16 collateral contact (CC) call, concern was voiced regarding Resident #1 being in the [redacted] with the [redacted] tied around [redacted] waist... during a visit to the AFH. [redacted] [Resident #1] seemed in distress, appeared to be struggling to get up and would pull at the [redacted] When the CC asked about the resident, Staff B made the comment, [redacted] fine..."

During the exit conference with the Provider 05/25/16 approximately 5:30 p.m., the Provider agreed the [redacted] could be seen as physical restraint and the staff knew this was wrong.

Further, in a 06/03/16 conversation with the nurse who covered the AFH, (Staff C), she said she had met with the staff right after the 05/25/16 on-site investigation to review abuse, neglect and restraints. Staff C sent the investigator a copy of the document which stated: "May 26, 2016: Teaching and reviewing done to caregivers regarding restraints, abuse, neglect, falls. They understand and read the policy of DSHS on restraints, abuse and neglect. They are aware to report all falls to RN, family and MD. They know to call the hotline number and police for any suspected abuse or neglect."

**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, MAGNOLIA HOME CARE is or will be in compliance with this law and / or regulation on (Date) 5/25/16 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

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

6/21/16  
\_\_\_\_\_  
Date

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