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

December 2, 2019

Anu R Thapa
Peter Gunter
EVERGREEN GARDENS II
1901 SHATTUCK AVE S
RENTON, WA 98055

RE: EVERGREEN GARDENS II License #752320

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on December 2, 2019 for the deficiency or deficiencies cited in the report/s dated October 28, 2019 and found no deficiencies.

The Department staff who did the inspection:
Olga Petrov, Licensor

If you have any questions please, contact me at (253) 234-6007.

Sincerely,

Elena Atanasova, Field Manager
Region 2, Unit G
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: EVERGREEN GARDENS II (719750) **Intake ID(s):** 3674456

License/Cert. #: AF752320

Investigator: Petrov, Olga **Region/Unit:** RCS Region 2/Unit G **Investigation Date(s):** 10/24/2019 through 10/28/2019

Complainant Contact Date(s): 10/23/2019, 10/25/2019

Allegations:

#1. Named Resident (NR) had trouble resting because NR's roommate was noisy.AFH promised private room but not moved. NR sleeps on a couch.

#2. NR was choking and it was serious.

#3.AFH had no caregivers during the night shift. NR is still sleeping on couch by the kitchen and doesn't have a call bell to notify staff if NR needs assistance.

#4.Staff did not received training on how to do straitening exercise to NR.

Investigation Methods:

[X] **Sample:**	NR and other resident in the home.	[X] **Observations:**	General care, resident condition, staffing and staff availability, response to call lights and alarms
[X] **Interviews:**	NR, NR's representative, staff interview, other not affiliated with the home	[X] **Record Reviews:**	NR, other resident assessment, care plans, staff record review

Residential Care Services

Investigation Summary Report

Allegation Summary:

#1. In an interview, NR said NR slept on the dining room recliner. Observation showed NR napped on the recliner in the dining room. In an interview, Co-Provider said NR's roommate had behavior outbreak and was noisy. Co-Provider said it was a single episode and it did not repeated since. Co-Provider and caregiver said NR slept on the recliner. Co-Provider said the home encourage NR to sleep in NR's room but NR refusing. Co-Provider said she replacing flooring in one of the room and planning to move NR after completion of the room remodel. #2. In an interview, NR , Co-Provider and caregiver said NR had episodes of chocking. Review of NR's negotiated care plan (NCP) showed NR needed to be monitored for chocking during meal time. NR's NCP showed that NR's fluids needed to be nectar thick consistency. In an interview, Staff said NR had milk and apple juice for his fluids intake. Staff said that she added three big scoops (tablespoon) of Thick It powder to big glass (21 ounces) to NR's liquids. Staff said NR chocked more when he drink his fluids. Staff said that NR "used to take whole glass" and Staff said NR "likes to finish very quickly. He drinks very fast" and NR cough. When asked how the AFH made nectar-thick liquids for the residents, Staff showed the Licensor the Thick -it container and pulled out 21 ounces glass from the dishwasher and mixed three scoops of the Thick-it powder.Observation of the label on the Thick-it container, indicated for nectar-thick consistency, mix three and half teaspoon (3 teaspoon = 1 tablespoon (scoop) to four ounces liquid. The cup the Staff used for the NR's liquids was for twenty one ounces. According to instruction and amount of the observed powder mixed with liquid, the Staff did not give NR nectar-thick liquids. Staff said that NR had episodes of chocking "once to two times a month when NR ate faster then normal while NR was drinking or eating." Staff said that she did not kept log of instances of NR's chocking.

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

#3.In an interview, Staff said Staff was a live-in caregiver and worked for the home twenty-four hours a day, six days a week and slept downstairs. Staff said Staff made a nighttime rounds. Staff said NR had a call button and other residents were not able to call. Observation showed a call button at NR's recliner. NR showed NR's call button. Review of residents' records showed they had cognition impairment and required assistance with their daily living .In an interview, the residents in the home said Staff was available at night to attend their needs.NR and other resident assessments and care plans up to date. Staff had valid background checks.

AFH failed to keep a log of multiple incidents of chocking involving 1 of 1 residents (NR) with difficulties swallowing.

#4. In an interview, Staff said Staff had been trained by health professional on NR's exercises. Staff said the home did daily straitening exercise to NR. Staff said Staff taken NR to outpatient straitening exercise once a week. Observation showed directions for NR's straitening exercises on the wall next to NR's bed. Interview with other not affiliated with the home, said Staff received professional training on NR's straitening exercise.

Conclusion / Action: ☒ **Failed Provider Practice Identified / Citation(s) Written** ☐ **Failed Provider Practice Not Identified / No Citation Written**

AFH failed to ensure one of two residents (NR) with swallowing difficulty were given nectar-thick liquids as ordered.

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NOV 15 2019
DSHS/ALTSA/RCS

Statement of Deficiencies	License #: 752320	Completion Date
Plan of Correction	EVERGREEN GARDENS II	October 28, 2019
Page 1 of 4	Licensee: PETER GUNTER & ANU THAPA	

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: 10/24/2019

EVERGREEN GARDENS II
1901 SHATTUCK AVE S
RENTON, WA 98055

This document references the following complaint number: 3674456

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

Olga Petrov, RN, Licensor

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2, Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032-2388
(253)234-6007

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.

Elsa Adams — Residential Care Services

11/05/2019 — 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)

11/10/2019 — 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:
(b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:
Based on observation, interviews and record review, the adult family home (AFH) failed to ensure one of two residents (Resident #1) with swallowing difficulty was given nectar-thick liquids as ordered. This failure placed Resident #1 at risk of aspiration and physical decline.

Findings included...

At the interview on 10/24/2019 at 08:30 AM, Staff B, Co-Provider, stated that Resident #1 had brain injury, feed himself and was [redacted] Staff B stated that Staff C, Caregiver was a live-in caregiver and worked for the home twenty-four hours a day, six days a week.

Record review on 10/24/19 showed that the AFH admitted Resident #1 on [redacted]19. Resident #1's 02/26/19 assessment under eating documented that he was on mechanically altered diet.

Resident #1's 04/18/19 negotiated care plan (NCP) under eating documented use of pureed food and nectar thick liquids. Under caregiver instruction documented, "Caregiver to make all his feed pureed and make drinks nector (sic) thick...Caregiver will monitor him while he is eating for chocking."

In an interview on 10/24/19 at 09:10 AM, Staff C stated that Resident #1 had swallowing problem and received a Thick-It (helps decrease the risk of choking and aspiration). Staff C stated that Resident #1 had milk and apple juice for his fluids intake. Staff C stated that Staff C added three big scoops (tablespoon) of Thick It powder to big glass of Resident #1's liquids. Staff C stated that Resident #1 chocked more when he drinks his fluids. Staff C stated that Residetn#1 "used to take whole glass" and the resident would like to finish very quickly. Staff C stated, "He drinks very fast and he cough".

On 10/24/19 at 10:20 AM, when asked how the AFH made nectar-thick liquids for the residents, Staff C showed the Licensor the Thick-it container and pulled out 21 ounces glass from the dishwasher. Staff C stated she observed Staff B mixed three big scoops of Thick-it to all of the resident's liquids.

Observation of the label on the Thick-it container 10/24/19 at 10:20 AM, indicated for nectar-thick consistency, mix three and half teaspoon (3 teaspoon = 1 tablespoon (scoop) to four ounces liquid. The cup the caregivers used for the Resident #1's liquids was for twenty-one ounces. According to instruction and amount of the observed powder mixed with liquid, the caregivers did not give Resident #1 nectar-thick liquids.

Observation 0n 10/24/2019 at 08:14 AM, showed that Resident #1 propel himself in his wheelchair from the bathroom to the dining room. Resident#1 was nonverbal and communicated with gestures.

In an interview on 10/24/2019 at 09:12 AM, when asked how the AFH made nectar-thick liquids

for the residents, Staff B said, "nectar thick." After looking at that Thick it in container label, she said that the AFH used ten teaspoon of thick It In powder for 12 ounces glass. Staff B said she needed to review Resident #1's liquids consistency with Staff C.

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, EVERGREEN GARDENS II is or will be in compliance with this law and / or regulation on (Date) 11-10-2019. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Provider (or Representative) — Date: 11-10-2019

WAC 388-76-10220 Incident log. The adult family home must keep a log of:
(2) Accidents or incidents affecting a resident's welfare; and

This requirement was not met as evidenced by:
Based on observations, interviews and record reviews, the adult family home (AFH) failed to keep a log of multiple incidents of chocking involving one of one residents (Residents #1) with difficulties swallowing. This failure prevented the AFH from having a record that identified patterns that required immediate action and prevention.

Findings included...

Observation 0n 10/24/2019 at 08:14 AM, showed that Resident #1 propel himself in his wheelchair from the bathroom to the dining room. Resident#1 was nonverbal and communicated with gestures.

At the interview on 10/24/2019 at 08:30 AM, Staff B, Co-Provider, stated that Resident #1 had brain injury, feed himself and was nonverbal. Staff B stated that Staff C, Caregiver was a live-in caregiver and worked for the home twenty-four hours a day, six days a week.

In an interview on 10/24/2019 at 09:10 AM, Staff C, Caregiver stated that Resident #1 had swallowing problem and received Thick-It (helps decrease the risk of choking and aspiration). Staff C stated that Resident #1 had milk and apple juice for his fluids intake. Staff C stated that Staff C added three big scoops (tablespoon) of Thick It powder to big glass of Resident #1's liquids. Staff C stated that Resident #1 chocked more when he drinks his fluids. Staff C stated that Resident #1 used to take whole glass and liked to finish very quickly. Staff C stated, "He [Resident #1] drinks very fast and he cough".

Record review on 10/24/2019 showed that the home admitted Resident #1 on [redacted]19. Resident #1's 02/26/19 assessment under eating documented that he was on mechanically altered diet.

Resident #1's 04/18/2019 negotiated care plan (NCP) under eating documented to use of pureed

food and nectar thick liquids. Under caregiver instruction documented, "Caregiver to make all his feed pureed and make drinks nector (sic) thick...Caregiver will monitor him while he is eating for chocking."

In an interview on 10/24/19 at 09:20 AM, Staff B stated that Resident #1 had episodes of chocking once to two times a month when he ate faster than normal while he was drinking or eating. Staff B stated that she did not kept log of instances of Resident #1's chocking.

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Provider (or Representative)

11-10-2019
Date