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

October 9, 2019

OVERLAKE VIEW ADULT FAMILY HOME LLC
OVERLAKE VIEW ADULT FAMILY HOME LLC
1917 JONES AVE NE
RENTON, WA 98056

RE: OVERLAKE VIEW ADULT FAMILY HOME LLC License #752432

Dear Provider:

On October 8, 2019 the Department completed a review of communication and / or documents from you indicating that you have corrected the deficiency or deficiencies cited in the report/s dated September 3, 2019.

Based on the review of this information the Department finds the deficiency or deficiencies have been corrected. Your home meets the adult family home licensing requirements.

The Department staff who did the off-site verification:
Lydia Owusu-Acheampong, Licensor

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

Sincerely,

Dahl Kim, Field Manager
Region 2, Unit E
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: OVERLAKE VIEW ADULT FAMILY HOME LLC (761890) **Intake ID(s):** 3660787

License/Cert. #: AF752432

Investigator: Owusu-Acheampong, **Region/Unit:** RCS Region 2/Unit E **Investigation Date(s):** 08/19/2019 through 09/03/2019

Complainant Contact Date(s): 08/22/2019

Allegations:

1. Care at this AFH has gone down for the past several months with high staff turnover.
2. AFH Owner has taken several vacations. Does not inform family of who is in charge when they are gone. Gone for 2 weeks and home not properly staffed.
3. Named resident (NR) had red eyes on 07/18/19.
4. NR slept in a chair in living room, only foreign channel showing on TV.
5. NR had not drank enough.
6. NR's had Broken glasses.

Investigation Methods:

[X] **Sample:**	3 residents including NR	[X] **Observations:**	Resident caregiver interactions, general observations, general care, general environment,
[X] **Interviews:**	2 residents including NR, Persons not affiliated with AFH, Caregivers.	[X] **Record Reviews:**	Incident log, resident records, negotiated care plan.

Residential Care Services

Investigation Summary Report

Allegation Summary:

1. During visit on 08/19/19, the AFH had two qualified staff on duty.
2. The Provider stated that they hired an experienced staff to manage the home while they travelled.The Provider stated that they had informed all resident's families verbally prior to their travel.

The Provider stated that while on vacation, they received reports that families were not happy with care from the newly hired staff. The Provider "fired" the staff right away. The Provider arranged with another AFH Provider to oversee the day-to-day operation until they returned. The Provider stated that the staff hired was experienced and they did not anticipate problems before they left.

Review of the hired by the AFH's record showed the Staff satisfied all the credentials required for long-term care workers.
3. In interview NR could not remember the eyes were red. There was no sufficient evidence to substantiate this.
4. Two individuals not affiliated with AFH interviewed stated that the home's television channels showed English channels. They both did not recollect seeing a foreign channel shown in the home.
5. Observations made throughout the visit showed Staff offered water to residents and encouraged them to drink almost every two hours.
Named resident when asked if he received water or drinks from the staff stated that they served them water and they drink when they are thirsty.
6. In interview, Staff stated that NR's glasses broke but the Provider fixed it. Observation showed NR wore the glasses. In interview a Person not affiliated with the AFH stated that the AFH fixed the broken glasses and had no concerns.
In interview with four persons not affiliated with the AFH, they stated that everything is back to normal since AFH "fired" the new staff away.
Negotiated care plan for NR and other sampled resident's were appropriate for their care assessments.

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

Other identified issue cited

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

See statement of deficiency dated 08/28/19.

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20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

Statement of Deficiencies	License #: 752432	Completion Date
Plan of Correction	OVERLAKE VIEW ADULT FAMILY HOME LLC	September 3, 2019
Page 1 of 3	Licensee: OVERLAKE VIEW ADULT FAMILY HOME LLC	

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: 8/19/2019

OVERLAKE VIEW ADULT FAMILY HOME LLC
1917 JONES AVE NE
RENTON, WA 98056

This document references the following complaint number: 3660787

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

Lydia Owusu-Acheampong, MSN, Licensor

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

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.

Elen Adams — 09/12/2019

Residential Care Services — 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.

[signature] — 9-19-2019

Provider (or Representative) — Date

WAC 388-76-10225 Reporting requirement.
(1) The adult family home must ensure all staff:
(a) Report suspected abuse, neglect, exploitation or abandonment of a resident:
(i) As required by chapter 74.34 RCW;
(ii) To the department by calling the complaint toll-free hotline number; and

This requirement was not met as evidenced by:
Based on observations, interviews and record reviews, the adult family home (AFH) failed to report to the Department hotline when they received report that one of one former staff (Staff K, caregiver) restricted the movement of one of one resident (R#3) in a wheel chair using a gait belt. This failure placed all vulnerable adults that may receive care from Staff K at risk of harm from not knowing patterns of this occurrence.

Findings included...

WAC 388-76-1000 Definition: (e) "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that:

(i) Is inconsistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW;
(ii) Is not medically authorized; or
(iii) Otherwise constitutes abuse under this section.

Upon entry on 08/19/19 at 10:20 AM and throughout visit ending 01:40 PM, R#3 lived and received care from the AFH staff.

In an interview on 08/19/19 at 12:26 PM, Staff A (Provider) stated that they hired another Staff K in addition to their two, Staff C (caregiver) and Staff L, (Former caregiver) to care for the residents while they went on vacation. Staff A stated that reports reaching them while on vacation showed the residents' families were not happy with how Staff K provided care to the residents. Staff A stated they instructed Staff K to leave (fired) while still on vacation.

On 08/22/19 at 03:25 PM, collateral contact #1 (CC1) stated that Staff K had tied R#3 to the wheelchair using a gait belt.

On 08/27/19 at 11:00 AM, collateral contact 4 (CC4) stated that Staff K "belted R#3 to a wheelchair." CC4 stated that Collateral contact 5 (CC5) saw this and stated that it was against regulation.

In a phone interview on 08/28/19 at 1:38 PM, Collateral contact 5 (CC5) stated that during one of their home visits, R#3 sat in a wheel chair with a gait belt around the back of the wheel chair, and fastened in front of R#3's chest. CC5 stated that one of the staff in close proximity was informed to remove the gait belt and educated them this was considered as a restraint. CC5 stated that this occurred just that one time. When asked which staff did this, CC5 stated that there were two staff on duty and CC5 could not tell which of them did tied the gait belt around the back of the wheelchair and fastened to the front chest of the resident.

Record review showed no documentation that R#3 had a medically authorized order for staff to

use gait belt when R#3 set in a wheel chair. Further review of R#3's negotiated care plan (NCP) dated 05/19/19 showed the AFH used of gait belt to transfer R#3 to and from the wheelchair. The NCP did not show caregivers needed to restrict R#3's movement using the gait belt.

In a phone interview on 08/28/19 at 10:48 AM, Staff A stated that R#3's representative had informed Staff A of the incident of the gait belt when they returned from vacation. When asked what Staff A did when informed of the incident, Staff A stated that Staff K had already been fired so they reassured R#3's representative that such things do not happen in their AFH and will not happen again.

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, OVERLAKE VIEW ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 9-19-2019. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Vyacheslav Sydor — 9-19-2019

Provider (or Representative) — Date