STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
316 W Boone Ave Ste 170, Spokane, WA 99201

April 5, 2021

Adult Care Living, LLC
In Loving Care Adult Family Home
3005 E 14th Avenue
Spokane, WA 99202

RE: In Loving Care Adult Family Home License #754536

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 1, 2021 for the deficiency or deficiencies cited in the report/s dated October 14, 2020 and found no deficiencies.

The Department staff who did the inspection:
Paula Wyatt, NCI/Community Complaint Investigator

If you have any questions please, contact me at (509) 323-7321.

Sincerely,

Carmen Church, FM

Carmen Church, Field Manager
Region 1, Unit E
Residential Care Services

Residential Care Services

Investigation Summary Report

Provider/Facility: In Loving Care Adult Family Home (1192563)
Intake ID(s): 3731754
License/Cert. #: AF754536
Investigator: Wyatt, Paula
Region/Unit: RCS Region 1/Unit E
Investigation Date(s): 10/06/2020 through 10/14/2020
Complainant Contact Date(s): 09/30/2020, 10/26/2020

Allegations:

Staff to resident communication.

Investigation Methods:

☒ **Sample:**	3 residents	☒ **Observations:**	Offsite investigation due to covid 19.
☒ **Interviews:**	3 residents provider 4 individuals not affiliated with the home	☒ **Record Reviews:**	Care plans assessments incident log video recording

Allegation Summary:

The adult family home had 6 residents receiving care and services. An anonymous source reported a video recording of communication between a staff member and a resident. In the recording the staff member did not communicate in a manner that promoted dignity and respect of the resident. The named resident was interviewed and stated the communication made them feel degraded and sad. Other residents did not verbalize any concerns. Deficient practice was identified regarding this issue.

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

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

Deficient practice was identified and a citation was written related to dignity and respect, WAC 388-76-10620 and can be found on the statement of deficiencies dated 10/14/2020.

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Statement of Deficiencies	License #: 754536	Completion Date
Plan of Correction	In Loving Care Adult Family Home	October 14, 2020
Page 1 of 3	Licensee: Adult Care Living, 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: 10/6/2020 and 10/9/2020
In Loving Care Adult Family Home
2215 S Sunrise Rd
Spokane Valley, WA 99206

This document references the following complaint numbers: 3730091 , 3731754
The department staff that inspected and investigated the adult family home:
Paula Wyatt, RN, NCI/Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1, Unit B
316 W Boone Ave Ste 170
Spokane, WA 99201
(509)323-7321

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.

Susan Beyer for Carmen Clark — 10/27/2020
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.

M Walters — 10/29/2020
Provider (or Representative) — Date

WAC 388-76-10620 Resident rights Quality of life General.
(1) The adult family home must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This requirement was not met as evidenced by:
Based on interview and record review, the provider failed to communicate in a manner that promoted dignity and respect for one of three sample residents (#1) when she spoke to the resident in a sharp tone and stated she would write her up. This resulted in the resident feeling upset, degraded and attacked. Findings included...

The July 2020 assessment showed Resident #1 had an intellectual disability, a mood disorder and anxiety. The negotiated care plan showed she may argue with peers and staff. The staff were instructed to allow the resident to be heard and understand Resident #1's point of view before explaining a situation.

During an interview with an anonymous source on 9/30/2020 at 3:30 PM, they stated they had received a video on 09/18/2020 at 3:24 PM of Staff A, Provider yelling at Resident #1, calling her sneaky and accusing the resident of doing something to another resident. The anonymous source stated Resident #1 told them she felt upset, degraded and attacked.

A review of the video on 09/30/2020 at 3:45 PM, showed Resident #1 was sitting at a table and another resident was observed toward the middle of the video in a nearby common area. In the video, Staff A could be heard speaking loudly with a sharp tone at Resident #1. Staff A told Resident #1 that everyone was afraid of her exploding and she would not live like that. Staff A said she worked too hard and too many hours to deal with somebody who kicks the other residents. Resident #1 yelled back "I didn't kick anyone, you guys are accusing me." Staff A told Resident #1 she would be getting written up and it would go in her file. She proceeded in the video to tell Resident #1 she was one of the "sneakiest girls" she had ever known, repeating it three more times, "You are sneaky, sneaky, sneaky." At that time, Staff A told another resident if it ever happened again, she wanted to be told immediately and would call the police to press charges. Resident #1 commented that Staff A was taking everyone else's side. Staff A replied she was taking into account what previous caregivers had told her about Resident #1 and had everything written in her file.

During an interview on 10/6/2020 at 4:10 PM, Staff A stated there was an altercation between Resident #1 and Resident #2. She said Resident #2 was assisting her in the kitchen the morning of 09/18/2020. Resident #1 had come into the kitchen to fix her meal when Staff A had to leave the area to take a telephone call. After Resident #1 left for work, Resident #2 was observed in a common area holding her leg. Resident #2 stated she wanted to call the police to press charges. When Staff A inquired, Resident #2 said she was kicked by Resident #1. Staff A stated she waited until the next day to sit down with both of the residents to discuss what had happened during the un-witnessed altercation. Staff A said Resident #2 shared what she thought happened and Resident #1, feeling accused cut Resident #2 off when she was speaking.

During an interview with Resident #1 on 10/9/2020 at 4:10 PM, she stated on 09/18/2020 Staff A and Resident #2 were making breakfast. Resident #1 said she was standing behind Resident #2 who backed up into her. Resident #1 said she may have kicked the resident. She stated the

next day Staff A wanted to talk to her regarding the incident with Resident #2. She stated she felt targeted and her "heart felt upside down" by the interaction she had with Staff A.

During an interview on 10/14/2020 at 8:48 AM, Staff A stated when Resident #1 argues with staff and peers, Resident #1 needs time and one on one interactions to ask questions to help her work things out. Staff A stated she does not get frustrated often with the residents but when she does she just needs time to work one on one to address the resident's needs. She said when it comes to Resident #1, she tends to treat her "like a daughter." She could not recall the exact communication reported in the video but agreed the interventions in the negotiated care plan should have been followed.

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, In Loving Care Adult Family Home is or will be in compliance with this law and / or regulation on (Date) 10/29/2020. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Provider (or Representative) — Date: 10/29/2020

Plan of Correction

In Loving Care AFH

License: #754536

WAC 388-76-10620-Resident Rights/Quality of Life/General

Going forward, and effective immediately, October 29th, 2020, I will only use methods outlined in residents care plan to resident feeling safe and not degraded or attacked. I will make sure I hear residents thoroughly, considering each residents uniqueness, disability and disorders, when it comes to communicating with each resident.

Moving ahead, I will ensure that this adult family home remains peaceful, regardless of the situation, or allegations which happen when I am around, and when I am not around, to witness. I will ensure that each resident is met with dignity and as any human being should be in the manner of speaking and when conflict arises between residents, staff, or both.

Chi Walters

CWalters