STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Mountain View AFH LLC

Mountain View AFH LLC
2545 Mountain View Road
Ferndale, WA 98248

RE: Mountain View AFH LLC License # 754721

Dear Provider:

This letter addresses Compliance Determination(s) 70343 (Completion Date 12/18/2025) and 68058 (Completion Date 11/07/2025).

The Department completed a follow-up inspection of your Adult Family Home on 12/18/2025 and found that you have corrected the violations listed in the Complaint report dated 11/07/2025. Your home is back in compliance as of 12/06/2025 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 388-76-10655-1, WAC 388-76-10655-2, WAC 388-76-10655-3, WAC 388-76-10655-4, WAC 388-76-10655-4-a, WAC 388-76-10655-4-b, WAC 388-76-10655-4-c, WAC 388-76-10655-5, WAC 388-76-10616-1, WAC 388-76-10616-1-a, WAC 388-76-10616-1-b, WAC 388-76-10616-1-c, WAC 388-76-10616-1-d, WAC 388-76-10616-1-e, WAC 388-76-10616-1-f

The Department staff who did the on-site verification:
Judith Mellon, RN, Licensor
Nicholette Flynn, AFH Field Manager

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn, AFH Field Manager

Region 2, Unit B
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 10/30/2025 and 11/07/2025 of:

Mountain View AFH LLC
2545 Mountain View Road
Ferndale, WA 98248

This document references the following complaint number(s): 197289

The following sample was selected for review during the unannounced on-site visit: 5 of 5 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Judith Mellon, RN, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

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.

Provider (or Representative) | Date

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

(1) Each resident's right to be free from physical and mechanical restraints used for discipline or convenience;

(2) Prior to the use of physical or mechanical restraints, less restrictive alternatives have been tried and documented in the resident's negotiated care plan;

(3) The physical or mechanical restraints have been assessed as necessary to treat the resident's medical symptoms and addressed on the resident's negotiated care plan; and

(4) If physical or mechanical restraints are used to treat a resident's medical symptoms, the restraints are applied and immediately supervised on-site by a:

(a) Licensed registered nurse;

(b) Licensed practical nurse; or

(c) Licensed physician.

(5) For the purposes of this section, "immediately 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 reviews, the Adult Family Home (AFH) failed to provide an alternative method in maintaining 1 of 5 resident’s (Resident 1) safety without the use of equipment and furniture as physical restraints. This failure resulted in Resident 1’s movement being restricted to their bed.

Findings included…

Per Washington Administrative Code 388-76-10000, "Mechanical restraint" means any device attached or adjacent to the vulnerable adult's body that they cannot easily remove and that restricts freedom of movement or normal access to their body. "Mechanical restraint" does not include the use of devices, materials, or equipment that are (a) medically authorized, as required, and (b) used in a manner that is consistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW.

Record review showed the AFH admitted Resident 1 on [redacted]/2022 with multiple medical diagnoses including [redacted].

Record review of Resident 1's combined assessment and care plan, dated 08/20/2025, showed Resident 1 had evidence of short-term memory loss, was not oriented to place or time, and poor decision-making skills regarding their daily life. The assessment showed Resident 1's decision making was severely impaired and never/rarely made decisions. Resident 1's assessment and care plan did not include any documentation regarding the need or use of restraints.

During a facility tour on 10/30/2025 at 3:00 PM, Staff A (Caregiver) opened Resident 1's door to their room. A full-size, uncovered bed mattress was turned on its longer side with two wheelchairs in the locked position against the mattress. The mattress had indentations where the wheelchairs were pushed against it. Staff A stepped past the bottom end of the full-size mattress and stood past the mattress next to a wall. Staff A stated Resident 1 was in bed and then moved away so the Department could fit past Staff A to be able to see Resident 1. Resident 1 was observed to be laying on their back in bed with the bed pushed against the wall. The full-size mattress was against Resident 1's bed preventing Resident 1 from being able to get out of bed.

In an interview on 10/30/2025 at 3:05 PM Staff A stated that it didn't bother Resident 1 to put the mattress there against the bed. Staff A stated that they do it for safety while making dinner. Staff A said, "I ask Resident 1 and Resident 1 tells me it's ok." Staff A stated Resident 1 cannot get up on their own without assistance.

In an interview on 10/30/2025 at 3:08 PM, Resident 1 was only able to state the word "yes" to any questions asked. Resident 1 was unable to state their name or provide any coherent responses to the Department's questions about the mattress against the bed.

In an interview on 10/30/2025 at 3:35 PM, Staff B (Provider) stated we put the mattress against the bed to keep Resident 1 from getting hurt. Staff B stated that Resident 1 liked it when staff put the mattress there.

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, Mountain View AFH LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____
Provider (or Representative) Date

WAC 388-76-10616 Resident rights Transfer and discharge notice.

(1) Before a home transfers or discharges a resident, the home must give the resident and the resident's representative a written thirty day notification informing them of the transfer or discharge. The home must also make a reasonable effort to notify, if known, any interested family member. The written notification must be in a language and manner the resident understands and include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location where the resident is transferred or discharged if known at the time of the thirty-day discharge notice;

(d) The name, address, and telephone number of the state long-term care ombuds;

(e) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with a developmental disability; and

(f) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of individuals with mental illness.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Adult Family Home (AFH) failed to ensure 1 of 5 residents (Resident 2) received a thirty-day discharge notice prior to discharge. This failure resulted in an unsafe and disorganized discharge.

Findings included…

Record review showed the AFH admitted Resident 2 on [redacted]/2025 with multiple medical diagnoses including [redacted] and [redacted]

[redacted].

Record review of an assessment dated 07/17/2025, showed Resident 2 had hallucination (thoughts of having seen, heard, touched, tasted, or smelled something that wasn't there) type behaviors and needed assistance with activities of daily living.

Record review of a negotiated care plan, undated, showed if Resident 2 was agitated, argumentative, and irritable caregivers should talk softly and give Resident 2 space to calm down.

In an interview on 10/30/2025 at 2:45 PM, Staff B (Provider) stated Resident 2 was requesting to go to the hospital to be checked for a urinary tract infection. Staff B stated Resident 2 was having behaviors such as yelling and paranoia. Staff B stated they were not able to reason with Resident 2.

In an interview on 10/30/2025 at 3:35 PM, Staff C (Caregiver-Bookkeeper) stated the discharge notice was not provided to Resident 2 while they were at the AFH. Staff C stated that the discharge notice was provided to Resident 2 only after they were sent to the hospital.

In an interview on 10/31/2025 at 9:21 AM, Collateral Contact 1 (CC1, outside agency) stated Staff B notified CC1 that Resident 2 was on route to the emergency room to be evaluated. CC1 stated Staff B said Resident 2 was having behaviors like yelling, arguing, and had previously fallen. CC1 stated that Staff B said they would not be taking Resident 2 back to the AFH. CC1 stated Staff B did not wait to see what the treatment was for Resident 2 and did not notify the outside agency to follow up on Resident 2. CC1 stated lab work was completed, and it looked like Resident 2 had a urinary tract infection.

Record review of an AFH notice of transfer or discharge showed the discharge notice was provided on [redacted]/2025 when Resident 2 was transported to the hospital. The discharge notice was unsigned by Resident 2 and showed Resident 2's "behaviors and actions could be summed up as 180 degrees out of line as compared to the rest of the residents and incompatible with the home" and was discharged effective [redacted]/2025. No thirty day notice was provided.

In a phone interview on 10/31/2025 at 2:45 PM, Staff B stated Resident 2 was admitted on [redacted]/2025 and did not have to provide a 30 day discharge notice since Resident 2 did not live at the AFH for very long.

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, Mountain View AFH LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Provider (or Representative) Date