STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Homestead Park AFH LLC
Homestead Park AFH LLC
1821 SE Solomon Loop
Vancouver, WA 98683

RE: Homestead Park AFH LLC License # 756589

Dear Provider:

This letter addresses Compliance Determination(s) 61029 (Completion Date 06/17/2025) and 51582 (Completion Date 03/27/2025).

The Department completed a follow-up inspection of your Adult Family Home on 06/17/2025 and found that you have corrected the violations listed in the Complaint report dated 03/27/2025. Your home is back in compliance as of 04/22/2025 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 388-76-10670-1, WAC 388-76-10670-2, WAC 388-76-10510-7

The Department staff who did the on-site verification:
Robert Hennig, NCI ALF Complaint Investigator

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just

Jody Just, Field Services Administrator
Region 3, Unit F
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

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 12/12/2024, 12/30/2024 and 01/15/2025 of:

Homestead Park AFH LLC
1821 SE Solomon Loop
Vancouver, WA 98683

This document references the following complaint number(s): 157994, 158011, 161213, 161052, 162311, 162335, 163499

The following sample was selected for review during the unannounced on-site visit: 4 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Robert Hennig, NCI ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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.

Clinton Fridley
Residential Care Services

04/08/2025
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.

******* UNTRUTHFUL STATEMENTS CONTAINED IN THIS REPORT *******

Provider (or Representative)

04/08/2025
Date

WAC 388-76-10670 Prevention of abuse. The adult family home must:

(1) Meet the requirements of chapter 74.34 RCW;

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

This requirement was not met as evidenced by:

Based on interview, observation and record review, the adult family home (AFH) failed to ensure they did not financially exploit 1 of 3 residents (Resident 4) when they withheld Resident 4 's(R4) property from the resident representatives after R4 passed away. This failure resulted in R4's representative from being able to either retrieve R4's property or being compensated appropriately

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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.

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(1) Meet the requirements of chapter 74.34 RCW;

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

This requirement was not met as evidenced by:

Based on interview, observation and record review, the adult family home (AFH) failed to ensure they did not financially exploit 1 of 3 residents (Resident 4) when they withheld Resident 4 's(R4) property from the resident representatives after R4 passed away. This failure resulted in R4's representative from being able to either retrieve R4's property or being compensated appropriately.

Findings Included...

Per WAC 388-76-1000, "Financial exploitation" means the illegal or improper use, control over, or withholding of property, income resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage.

Review of R4's facility records revealed that R4 was admitted to the AFH on [redacted]/2022, discharged on [redacted]/2024, with diagnoses including [redacted] and [redacted].

Review of R4's negotiated care plan (NCP), dated 07/14/2024, showed that R4 required two-person assistance and use of a [redacted] for transfers to and from bed.

Record review of an invoice from [redacted] Systems, dated 11/08/2024, showed that a [redacted] system was installed at the AFH on 11/07/2024 and cost $8,217.72 and was billed to R4.

Review of Department caseworker internal records, via program titled "ACES", documented the [redacted] system was approved, and purchased for R4 with [redacted] funds.

On 12/13/2024 at 1:00 PM, during a telephone interview with R4's representative (CC1), CC1 stated the property owner (PO) of the adult family home, requested CC1 provide a [redacted] system [redacted] to be installed in R4's room to assist with transfers. CC1 stated R4's case worker assisted with the purchase and installation of the [redacted] system [redacted] and it was installed on 11/07/2024. CC1 stated the [redacted] was utilized for transfers of R4 until R4 passed away on [redacted]/2024. CC1 stated arrangements were being discussed with PO regarding retrieving R4's property, which included the [redacted] system on 11/25/2024. Per CC1, PO stated they believed the [redacted] system was the property of the AFH, despite CC1 stating to PO they had confirmed, with R4's caseworker, the [redacted] system belonged to R4, and after R4 passed away, would belong to R4's representative. CC1 stated PO offered $2,000 for the [redacted] system that was installed in R4's room. Per CC1, PO stated that if CC1 did not take the offer, CC1 would need to obtain an attorney to prove ownership of the [redacted] system. CC1 stated PO refused to allow CC1 to enter the home and retrieve R4's possessions after 11/27/2024, which included the [redacted] system and other possessions.

During an interview and observation at the AFH on 12/30/2024 at 12:35 PM, caregiver (S1) confirmed which Resident room belonged to R4, and the [redacted] system was observed to still be installed in the room.

On 12/30/2024 at 1:50 PM during an interview with the resident care manager (RCM), they stated that PO informed them the [redacted] system was donated by R4's representative after R4's passing.

On 01/02/2025 at 10:39 AM, an email to the Department, from Provider, was reviewed and documented the Provider stating the Provider and PO previously worked together as caregivers and resident managers serving clients. The email stated the reason for PO interacting with clients in the Provider's home was because of PO's familiarity with the business and some of the current clients. The email stated some of the clients and their family members continued to reach out to PO for various care needs such as transportation, medication, and appointment scheduling. The email stated the clients

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On 01/09/2025 at 11:03 PM, an email to the Department, from RCM, was reviewed and documented that RCM stated a police investigator interviewed PO regarding the ownership of the [redacted] system. The email stated PO stated to the police investigator they were unsure of ownership and contacted the adult family home council and an attorney, both of which stated they believed the property was the homes, not R4's representative. No mention of contacting the Department caseworker regarding ownership of the [redacted] system was noted.

On 01/15/2025 at 1:10 PM a review of an invoice from [redacted] Systems dated 11/08/2024 indicated a [redacted] system was installed on 11/07/2024 at the adult family home for $8,217.72 and billed to R4.

During a telephone interview with PO on 02/04/2025 at 2:30 PM, PO stated he was assisting with the operation of the home for the Provider because he had previously managed the home and felt it was good for the residents and families. PO stated they no longer have anything to do with the AFH. PO stated CC1 had verbally stated, prior to R4's passing, they would like to donate the [redacted] system (to the AFH). PO stated it was PO's fault for not getting the donation of the [redacted] system in writing. PO stated they should have contacted R4's case worker to inquire about ownership of the [redacted] system and should not have spoken for the AFH regarding R4's [redacted] system. PO stated he refused to allow CC1 in the home after R4's passing to retrieve the remaining possessions, including the [redacted] system, until they confirmed ownership of the [redacted] system.

During a telephone interview with CC1, on 03/19/2025 at 3:05 PM, CC1 stated the [redacted] system has not been returned due to CC1's legal council's advice pending legal action being pursued regarding R4's possessions not being returned.

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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, Homestead Park AFH LLC is or will be in compliance with this law and / or regulation on (Date) 04/22/2025 .

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

******* UNTRUTHFUL STATEMENTS CONTAINED IN THIS REPORT *******

Provider (or Representative) | Date: 04/08/2025

WAC 388-76-10510 Resident rights Basic rights. The adult family home must ensure that each resident:

(7) Is cared for in an environment that is safe, clean, comfortable, and homelike; and

This requirement was not met as evidenced by:

Based on observation and interview, the provider failed to provide a safe, clean, comfortable, and homelike environment for 1 of 3 residents (Resident 1) by plugging an extension cord from outdoors into an outlet in Resident 1's (R1) bedroom through the window. This failure resulted in R1 not feeling comfortable, homelike and safe in their room.

Findings included...

During a telephone interview with Collateral Contact 3 (CC3) on 12/02/2024 at 2:00 PM, CC3 stated they have witnessed the extension cord plugged in an outlet in (R1's) room through the window. CC3 stated R1 has repeatedly asked staff to remove the cord and close their window because of a draft and concerns about insects entering the room as well as concerns about the possibility of a fire from the plug. CC3 stated the extension cord leads to an outdoor shed with a refrigerator.

On 12/30/2024 at 12:50 PM, during an unannounced on-site investigation, this investigator observed an extension cord plugged in R1's outlet through an open window with no screen and opened approximately five inches.

On 12/30/2024 at 12:55 PM, during an interview with R1, R1 stated the home, under a different license, was cited for the extension cord plugged in the wall through the window. R1 stated they have repeatedly asked the Provider to remove the plug and close their window with no resolution.

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On 02/04/2025 at 2:30 PM, during an interview with the property owner (PO), PO stated the electrical cord in R1's window had been corrected from a previous citation, however, believes R1 goes outside and plugs the electrical cord through their window to get PO in trouble. PO stated R1 can be mean and spiteful towards PO.

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, Homestead Park AFH LLC is or will be in compliance with this law and / or regulation on (Date) 12/30/2024 .

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Provider (or Representative)	Date

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