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

OVENELL HOME ALF INC

OVENELL HOME ALF INC
625 E Washington Ave
Burlington, WA 98233

RE: OVENELL HOME ALF INC License # 2172

Dear Administrator:

This letter addresses Compliance Determination(s) 26568 (Completion Date 07/12/2023) and 21310 (Completion Date 04/21/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/12/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2630-1-a

The Department staff who did the on-site verification:
Cristina Gonzalez, ALF Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: OVENELL HOME ALF INC **Provider Type:** Assisted Living Facility
License/Cert.#: 2172
Compliance Determination #: 21310 **Intake ID:** 71154
Investigator: Teresa Pederson-Tuley **Region/Unit #:** RCS Region 2 / Unit A
Investigation Date(s): 03/20/2023 through 04/21/2023
Complainant Contact Date(s): 03/16/2023, 04/11/2023

Allegation(s):
It was alleged that the Named Resident left the facility and did not return for twenty-four hours.

Investigation Methods:

Sample:	Total residents: 22 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Identified resident Staff to resident interactions Resident to resident interactions
Interviews:	Administrator Designee Residents Caregivers
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:
According to interview and record review:
The named resident left the facility and was missing overnight. The facility did not investigate or report the incident, notify the physician, case worker, hotline, or notify law enforcement. Furthermore, there is no documentation that the named resident was assessed for injury following return to the facility. Failed practice identified; WAC 388-78A-2371 Investigations and WAC 388-78A-2630 Reporting abuse and neglect.

Conclusion / Action:

- ☐ Failed Provider Practice Identified / Citation(s) Written
- ☒ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A

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

Statement of Deficiencies	License #: 2172	Compliance Determination # 21310
Plan of Correction	OVENELL HOME ALF INC	Completion Date
Page 1 of 5	Licensee: OVENELL HOME ALF INC	04/21/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 03/20/2023 and 04/18/2023 of:

OVENELL HOME ALF INC
625 E Washington Ave
Burlington, WA 98233

This document references the following complaint number(s): 71154

The following sample was selected for review during the unannounced on-site visit: 3 of 22 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Teresa Pederson-Tuley, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
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.

Kim Rogers — Residential Care Services

5-5-23 — Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

5/15/23
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to document and thoroughly investigate a missing Resident for 1 of 1 sampled resident (Resident 1). The ALF failed to document details of the occurrence, collect witness statements, show how abuse or neglect was ruled out, and interventions to prevent and protect Resident 1. This failure placed Resident 1, at risk for harm, unidentified care needs and a diminished quality of life.

Findings Included...

Review of the Assisted Living Guidebook; Partners in Protection dated 02/2018 showed State law requires the assisted living facility to do a thorough investigation of the incident. In order for the facility to provide evidence of the thoroughness of the investigation the information must be documented. The investigation should include data collection to identify who, what, when and where. The data analysis should answer how and why of the incident.

Resident 1 was admitted to the facility [redacted], 2009, with a diagnosis of [redacted], and [redacted] Resident 1 was dependent upon the facility staff to provide Activities of Daily Living (ADL's), medication assistance, and mental health services.

On 03/20/2023 in an interview at 12:05 PM Resident 1 stated that he left the facility and walked to Mount Vernon Washington. Resident 1 stated he walked until it was dark then he laid on the ground to sleep in a church doorway because he did not know how to get home. Resident 1 stated the next morning he asked a stranger to help him find a bus station, and that the bus driver paid for his ride and helped him get home.

On 03/20/2023 in an interview at 1:41 PM Staff A, Administrator Designee, stated that he

did not know what time Resident 1 left the building on 02/19/2023 and that the time documented on the Incident report was a close guess, as was the time the resident returned on 02/20/2023. Staff A stated that he thought the incident report had enough information and considered it to be the investigation.

Record review of the Incident Report dated 02/19/2023 showed Resident 1 left the building and did not sign out. The incident report was not followed up by an investigation, and an investigation was not started within 24 hours. The incident report failed to include:
Any incident details,
An accurate time when Resident 1 left the ALF or returned to the ALF,
Why Resident 1 left,
Which staff were working at the time of the incident,
Interviews with staff, witnesses, Resident 1,
Any attempts to locate Resident 1,
Review of Resident 1's care plan, medications, cognitive status, social and psychological history, or capacity to safely navigate being alone in the community,
An assessment of Resident 1's mental and physical wellbeing upon return, physical exam, diagnostic labs if needed,
If or how abuse or neglect was ruled out,
Any interventions or preventative actions.

Plan/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, OVENELL HOME ALF INC is or will be in compliance with this law and / or regulation on (Date) 6/30/23 .

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

Administrator (or Representative) — Date 8/16/23

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to report to Law Enforcement and the Department for 1 of 1 sampled resident (Resident 1) when Resident 1 left the ALF and was unaccounted for overnight. This failure placed the resident at risk of harm and a diminished quality of life.

Findings included...

Review of the Assisted Living Guidebook; Partners in Protection dated 02/2018 showed facilities are required to report to the Department's 24 hour hotline when there is reasonable cause to believe the act caused a fear of imminent harm; and to Law Enforcement when there is reasonable cause to believe that an act has caused imminent harm. The report should be made immediately by telephone or online.

Record review of the ALF's undated policy titled "Resident Absence/Missing Resident" showed: the staff will monitor and supervise residents and have a general idea of their whereabouts at all times.

3. If the resident cannot be found in or around the facility within 4 hours of his/her noticed absence when he/she has not signed out, staff will 1st contact the Administrator, notify State Hotline along with other emergency and contact numbers in an attempt to locate the resident.

4. If a resident cannot be found in or around the facility, has not signed out, and has a history of confusion or dementia, emergency and other contact numbers will be used immediately to locate the resident, within two hours from the time he/she is listed as missing. If he/she still cannot be found, police will be contacted to assist in locating the resident.

Resident 1 was admitted to the facility [redacted], 2009, with a diagnosis of [redacted] and [redacted]. Resident 1 is dependent upon the facility staff to provide Activities of Daily Living (ADL's), medication assistance, and mental health services.

Record Review of the Medication Administration Record dated February 2023, showed that Resident 1 did not receive his evening medications and on 02/20/2023 did not receive his morning medications, which included anti-psychotic medications for AM and PM.

On 03/20/2023 in an interview at 12:05 PM Resident 1 stated that he left the facility and walked to Mount Vernon Washington, because he was upset when he overheard staff talking about another Resident. Resident 1 stated he walked until it was dark then laid on the ground to sleep in a church doorway, because he did not know how to get home. Resident 1 stated the next morning he asked a stranger to help him find a bus station, and that the bus driver paid for his ride and helped him get home.

On 03/20/2023 in an interview at 1:41 PM Staff A, Administrator Designee, stated that he did not report to the hotline or law enforcement, and did not know that a report was

necessary. Staff A stated that he did not know what the facility policy stated about missing residents or what action needed to be taken.

Record review of the Incident Report dated 02/19/2023 showed that Resident 1 was out of the facility from 11:30 AM 02/19/2023 and returned at 7:00 AM on 02/20/2023. There was no documentation in the resident record that showed the hotline, law enforcement, case workers and physician were notified.

Plan/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, OVENELL HOME ALF INC is or will be in compliance with this law and / or regulation on (Date) 6/30/23.

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

Administrator (or Representative) — Date: 5/16/23