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

04/18/2024

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) 39850 (Completion Date 04/17/2024) and 32556 (Completion Date 02/15/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/17/2024 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:
RCW 70.129.110.3.a, RCW 70.129.110.3, RCW 70.129.110.3.b, RCW 70.129.110.3.c, RCW 70.129.110.3.d, RCW 70.129.110.5.a, RCW 70.129.110.5.b, RCW 70.129.110.5.c, RCW 70.129.110.5.d, WAC 388-78A-2660-1

The Department staff who did the on-site verification:
Christine Banta, ALF Licensor

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, 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 #:** 32556 **Intake ID:** 105342
**Investigator:** Teresa Pederson-Tuley **Region/Unit #:** RCS Region 2 / Unit A
**Investigation Date(s):** 11/15/2023 through 02/15/2024
**Complainant Contact Date(s):**

**Allegation(s):**
The Named Resident (NR) told the Administrator Designee (AD) that they had used drugs. The AD stated that they were evicted immediately and was not given a 30 day discharge notice.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 22<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Residents<br>Dining<br>Staff to resident interactions |
| **Interviews:** | Identified resident<br>Administrator Designee (AD)<br>Staff |
| **Record Reviews:** | Medical records<br>Hospital records<br>Incident investigation<br>Facility policies |

**Investigation Summary:**
The Named Resident (NR) told the Administrator Designee (AD) that they had used drugs that day. The AD stated to the NR that they were evicted from the Assisted Living Facility (ALF) immediately. The AD did not help the NR formulate a safe discharge plan, did not give the NR a 30 day discharge notice, and the NR became homeless. Failed practice was identified. A citation was issued for noncompliance with WAC 388-78A-2660 Resident rights.

**Conclusion / Action:**

- [x] 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 # 32556 |
| Plan of Correction | OVENELL HOME ALF INC | Completion Date |
| Page 1 of 4 | Licensee: OVENELL HOME ALF INC | 02/15/2024 |

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 11/15/2023 and 11/15/2023 of:

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

This document references the following complaint number(s): 105342

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 Ripley
Residential Care Services

02/23/2024
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)

3/19/24
Date

**RCW 70.129.110 Disclosure, transfer, and discharge requirements.**

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(5) The written notice specified in subsection (3) of this section must include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location to which the resident is transferred or discharged;

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

**WAC 388-78A-2660 Resident rights. The assisted living facility must:**

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to make reasonable accommodations to avoid discharge for 1 of 3 residents (Resident 1), failed to provide 30 days notice, and the written notice failed to include a date of discharge, location of discharge and the contact information for the Ombudsmen's office. This failure resulted in Resident 1 having to leave their home of eight years with no notice, without a safe discharge plan, with unmet health needs, and homelessness.

Findings included...

Resident 1
Resident 1 was admitted to the facility on [redacted] 2015 with Aphasia (a person is unable to formulate language because of brain damage). Hemiplegia (one side of the body does not work), and needed a wheelchair, a leg brace, a 4-legged cane for mobility and required full assistance with transfers.

The ALF policy titled, "Ovenell Home LTC, INC Rules and Policies", showed if the ALF transfers or discharges a resident, the ALF shall provide a written notice of discharge to the resident and his or her legal representative at least 30 days in advance. Before transferring or discharging a resident, the ALF will attempt, through reasonable accommodations, to avoid the transfer or discharge.

The ALF's "Nursing Home Transfer or Discharge Notice DSHS 10-237 (REV. 12/2018)" dated [redacted]/2023, showed that the resident was given the discharge notice on [redacted]/2023. The notice showed the reason for the discharge was "The health of other individuals in this facility would otherwise be endangered. Was using and possessing meth on property. Police have ongoing investigation. House rules call for immediate discharge." The location of the discharge was Skagit Valley Hospital. The effective date was left blank. A note on the form showed "The effective date must be at least 30 days from the date of the notice." The notice failed to include the Ombudsmen's contact number.

An Admit & Health record dated [redacted]2015 did not show that that Resident 1 used drugs, had a behavior diagnosis, or a history of violence.

Progress Notes dated 09/2023 showed seven entries for the month. Resident 1 was noted to be "ok and medication compliant" multiple times. One entry dated 9/1/23 showed Resident 1 was high on THC. There were no behaviors or violence documented.

Progress Notes dated 10/2023 showed seven entries for the month. Resident 1 was noted to be "ok and medication compliant" multiple times. There were no behaviors or violence documented.

Progress Notes dated 11/2023 showed two entries on [redacted]/2023. Resident 1 was noted to be "in over dose, we needed to call 911 to ask for help they took him to the hospital." There were no behaviors or violence documented.

The Care Plan dated 04/16/2023 for Resident 1 showed no interventions for behaviors, violence, or drug use.

Hospital social worker (SW) notes dated [redacted]/2023 showed that the hospital SW spoke to Staff A, Administrator Designee. Staff A reported to the SW that Resident 1 was not allowed back. "It was an immediate discharge, per their contract, if drugs are found or used." Resident 1 was not welcome back until after treatment." Staff A stated that "He wondered if this was a safe discharge plan."

On 11/15/2023 at 7:57 AM, Collateral Contact, Caseworker, stated Resident 1 had significant mobility issues, had lived at the ALF for eight years, does not have a history of violence, and was discharged from the hospital emergency department with nowhere to go.

On 11/15/2023 at 1:00 PM, Staff A stated that Resident 1 had admitted to using drugs, he kicked Resident 1 out of the facility immediately, the health of the other residents would be endangered, the resident was violent, and "he did not give the resident a 30-day notice".

On 01/24/2024 at 10:54 AM, Resident 1 stated they had lived at the ALF since 2015, had used drugs that day and asked Staff A for help. Staff A stated that they were evicted immediately. Resident 1 stated that they were transferred to the hospital and discharged with no place to go. Resident 1 stated they were never violent and would not harm his friends at the ALF. Resident 1 stated that he did not receive a 30-day notice, was not offered help to find a place to live and as a result became homeless.

**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) 3/31/24 .

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

Administrator (or Representative) — Date: 3/19/24