STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

ANDERSON LOVING CARE AFH LLC

ANDERSON LOVING CARE AFH LLC
12621 84TH AVE S
SEATTLE, WA 98178

RE: ANDERSON LOVING CARE AFH LLC License # 751440

Dear Provider:

This letter addresses Compliance Determination(s) 73852 (Completion Date 03/04/2026) and 71070 (Completion Date 02/17/2026).

The Department completed a follow-up inspection of your Adult Family Home on 03/04/2026 and found that you have corrected the violations listed in the Complaint report dated 02/17/2026. Your home is back in compliance as of 02/28/2026 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, WAC 388-76-10670-4

The Department staff who did the on-site verification:
Vadim Panitkov, NCI

If you have any questions, please contact me at (253)234-6007.

Sincerely,

Lydia Owusu-Acheampong, Community Field Manager
Region 2, Unit G
Residential Care Services

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Statement of Deficiencies	License #: 751440	Compliance Determination # 71070
Plan of Correction	ANDERSON LOVING CARE AFH LLC	Completion Date
Page 1 of 4	Licensee: ANDERSON LOVING CARE AFH LLC	02/17/2026

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 01/06/2026 and 02/02/2026 of:

ANDERSON LOVING CARE AFH LLC
12621 84TH AVE S
SEATTLE, WA 98178

This document references the following complaint number(s): 206373

The following sample was selected for review during the unannounced on-site visit: 3 of 4 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Vadim Panitkov, NCI

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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 — 2-17-2026 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) — 2/23/2026 Date

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

(4) Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to implement their "ABUSE & NEGLECT REPORTING PROCEDURE" for 1 of 1 sampled resident (Resident 1) when Resident 1 reported physical assault by Resident 2. This placed all residents at risk of unrecognized or unreported abuse and subsequent delay in having an intervention to protect residents in case abuse, exploitation or neglect occurred.

Findings included...

On 01/06/2026 at 3:58 PM, in a telephone interview, Collateral Contact 1 (CC) stated that Resident 1 reported to them that they were stabbed with a fork by another resident at the AFH.

On 01/07/2026 at 1:30 PM, observation showed Residents 2, 3, and 4 with Staff D, Caregiver. Resident 1 was out of facility for a physician's appointment. Staff C, Designated Resident Manager, arrived shortly after.

On 01/07/2026 at 1:52 PM, Department Staff (DS) attempted to interview Resident 2. Resident 2 yelled at DS and declined to be interviewed.

01/07/2026 at 2:09 PM, in an interview, Staff C stated that Resident 1 reported to a caregiver that Resident 2 stabbed their hand with a fork on 12/13/2025. Staff C stated that no caregiver saw the incident. Staff C stated that Resident 2 denied the incident and declined further interviews. Staff C stated that they reported this incident to CC 1 on 12/20/2025. Staff C stated that they did not report this incident to departments hotline as they did not suspect the incident occurred. Staff C stated that they completed training with the AFH staff and that it was a mistake not reporting.

On 01/07/2026 in a record review of AFH's incident report dated 12/13/2025 showed that at around 4:35 PM, Residents 1 and 2 were eating dinner at the dining room. The incident report showed that Residents 1 and 2 were arguing. The incident report also showed that Resident 1 had a bruise on their right hand. Staff E, Caregiver, questioned Resident 1 who blamed Resident 2 for the bruise. Resident 2 remained quiet.

On 02/02/2026 at 11:25 AM, on an additional unannounced onsite visit, observation showed Residents 1, 2, 3, and 4 with Staff D, Caregiver.

On 02/02/2026 at 11:34 AM, DS attempted to interview Resident 2. Resident 2 declined to be interviewed.

On 02/02/2026 at 11:38 AM, in an interview, Resident 1 stated that while they were sitting in kitchen dining room eating a meal, Resident 2 got angry and stabbed their hand with a fork. Resident 1 could not recall the date of the incident.

On 02/13/2026 a record review of AFH's undated "ABUSE & NEGLECT REPORTING PROCEDURE" showed that "[AFH] Personnel (meaning licensees/providers/staff) are mandated reporters and must comply with all applicable licensing laws and regulations at all times. [AFH] staff must ensure that the facility and the individual mandated reporting responsibilities are done as soon as possible." Additionally, the policy showed that "Each staff member must always use good judgment in deciding the best course of action to be taken to protect their residents following discovery or report of an incident or allegation of abuse, neglect, exploitation, abandonment, or, resident death." The policy also showed that "You must report to both DSHS and Law Enforcement if you witness or suspect any of the following: Physical assault; Sexual abuse; or An incident of physical assault between vulnerable adults which causes more than minor bodily injury. Incidents between vulnerable adults: If a physical assault between vulnerable adults results in minor bodily injury (not requiring more than basic first aid) it must be reported to DSHS."

On 02/17/2026 at 8:06 AM, in a telephone interview, Staff E stated that they heard Resident 1 and Resident 2 arguing in the dining room on 12/13/2025. Staff E stated that Resident 1 had some blood on the right hand. Staff E asked Resident 1 what happened, Resident 1 stated that Resident 2 stabbed them with a fork. Staff E stated that Resident 2 did not say anything. Staff E stated that they reported this to Staff C that same evening.

Statement of Deficiencies	License #: 751440	Compliance Determination # 71070
Plan of Correction	ANDERSON LOVING CARE AFH LLC	Completion Date
Page 4 of 4	Licensee: ANDERSON LOVING CARE AFH LLC	02/17/2026

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, ANDERSON LOVING CARE AFH LLC is or will be in compliance with this law and / or regulation on (Date) 02/28/2026 .

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

Provider (or Representative) — Date: 2/23/2026