STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

CARING ANGELS ADULT FAMILY HOME

CARING ANGELS ADULT FAMILY HOME
1515 SOUTH 28TH PLACE
RENTON, WA 98055

RE: CARING ANGELS ADULT FAMILY HOME License # 752250

Dear Provider:

This letter addresses Compliance Determination(s) 28617 (Completion Date 08/28/2023) and 22623 (Completion Date 06/27/2023).

The Department completed a follow-up inspection of your Adult Family Home on 08/28/2023 and found that you have corrected the violations listed in the Complaint report dated 06/27/2023. Your home is back in compliance as of 07/13/2023 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 388-76-10670-3, WAC 388-76-10670-4

The Department staff who did the on-site verification:
Jennifer Domingo, AFH Complaint Investigator

If you have any questions, please contact me at (253)234-6033.

Sincerely,

Cecile Leano, Field Manager
Region 2, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: CARING ANGELS ADULT FAMILY HOME
Provider Type: Adult Family Home
License/Cert.#: 752250
Intake ID: 75643
Compliance Determination #: 22623
Region/Unit #: RCS Region 2 / Unit E
Investigator: Jennifer Domingo
Investigation Date(s): 04/17/2023 through 06/27/2023
Complainant Contact Date(s):

Allegation(s):
Named Resident 1 (NR 1) now Former Resident (FR) was found by Named Resident 2 (NR 2) beating Named Resident 3 (NR 3) on their bed during the night in the Adult Family Home (AFH). NR 3 suffered injuries that required hospitalization.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 4 Closed records sample size: 1
Observations:	General observation, residents' appearance, staff interaction with residents and resident to resident interactions.
Interviews:	Residents and staff.
Record Reviews:	Residents, hospital records and AFH records.

Investigation Summary:
During the unannounced visit, observation showed that the home had a split entry level with stairs ascending to the upper level and stairs descending to the lower level. Observation showed FR and NR 3 shared the same bedroom in the lower level. Staff's bedroom was on the upper level. Observation showed FR was not in the home. Observation showed NR 3 had purple, greenish bruised on their face and left elbow. NR 3 was alert and conversant during the interview. NR 3 stated that on the morning of 03/22/2023 (first incident), FR pushed them down the stairs by the home's front door. NR 3 fell to their left side and their buttocks. NR 3 was sent to the hospital via Emergency Medical Services (EMS). Hospital record showed NR 3 returned to home the same day from the hospital after a negative work-up. On the night of 03/22/2023 (second incident), NR 3 stated that they were asleep and thought they had a nightmare. NR 3 yelled out, "Stop, stop, stop!". NR2, who lived on the upper level stated that they heard a commotion downstairs. NR 2 checked on the commotions and found FR beating up NR 3 in their bed. NR 2 immediately ran upstairs and called staff for help. NR 3 stated that FR beaten them up on their face while asleep. Staff called EMS and staff separated FR from NR 3. Law enforcement and EMS came and took NR 3 to the hospital. Record review of hospital notes revealed that NR 3 had multiple fractures on

their face. Staff stated that they notified FR's Department of Correction Officer, Department hotline, Case Managers, and their collateral contact. Staff stated that they did not monitor FR and NR 3 when NR 3 returned from the hospital after the first incident. Staff failed to protect the NR 3 from FR.
Failed Provide practice identified. See Statement of Deficiencies dated 06/27/2023. WAC 388-76A-10670 (3) (4) Prevention of abuse

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Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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Statement of Deficiencies	License #: 752250	Compliance Determination # 22623
Plan of Correction	CARING ANGELS ADULT FAMILY HOME	Completion Date
Page 1 of 4	Licensee: CARING ANGELS ADULT FAMILY HOME	06/27/2023

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 04/17/2023, 04/17/2023 and 04/17/2023 of:

CARING ANGELS ADULT FAMILY HOME
1515 SOUTH 28TH PLACE
RENTON, WA 98055

This document references the following complaint number(s): 75643

The following sample was selected for review during the unannounced on-site visit: 4 of 5 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Domingo, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit E
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 — 06/30/2023 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)

7/7/2023
Date

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

(3) Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion; and

(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 ensure that one of two sampled residents (Resident 1) was protected from abuse after they were first assaulted by another resident. This failure resulted in Resident 1 being assaulted twice and suffering multiple injuries that required hospitalization.

Findings included...

During an unannounced visit to the AFH on 04/17/2023 at 9:42 AM, observation showed that the home had a split entry level with stairs ascending to the upper level and stairs descending to the lower level. Observation showed that Resident 1 and Resident 2 were roommates, and their bedroom were on the lower level. The caregiver's bedroom was on the upper level. Resident 2 was observed not in the home.

On 04/17/2023 at 10:19 AM, observation showed Resident 1 had a bruise to their left elbow and bruise on the left side of their face.

In an interview on 04/17/2023 at 10:23 AM, Resident 1 stated that they shared a bedroom with Resident 2. Resident 1 stated that they were assaulted twice by Resident 2. The first assault incident occurred in the morning of 03/22/2023. Resident 1 stated that they argued with Resident 2 and Resident 2 pushed them down the stairs by the home's front door. Resident 1 stated that they were brought to the hospital and returned home the same

day. Resident 1 stated that they sustained bruises to their tailbone, and pain to their back, left arm, left shoulder, and left leg from the first assault incident. The second assault incident occurred on the night of 03/22/2023. Resident 1 stated that they were asleep in bed and woken up to Resident 2 assaulting them. Resident 1 stated that Resident 2 repeatedly hit them on their face and ear.

In an interview on 04/17/2023 at 11:29 AM, Staff A, Provider, stated that Resident 2 was admitted at the home on [redacted]/2023 from a local mental health facility. Staff A stated that on the morning of 03/22/2023, Resident 1 and Resident 2 had an argument. Resident 2 pushed Resident 1 down the stairs and the Emergency Medical services brought Resident 1 to the hospital. Staff A stated that Law Enforcement (LE) did nothing to Resident 2 but talked to them about the incident. Staff A stated that Resident 2 informed them that they snapped at Resident 1. Staff A stated that they did not monitor Residents 1 and 2 after the first incident because Resident 2 spoke with LE and Staff A that they would not hurt Resident 1 again. Staff A stated that after the second incident, LE arrested Resident 2 after they assaulted Resident 1.

Review of Resident 2's assessment, dated 12/20/2022, showed Resident 2 had seven different times of inpatient [redacted] health facility admissions. Resident 2 had Schizophrenia (a serious mental disorder in which people interpret reality abnormality. [redacted] diagnosis. Assessment showed that Resident 2 had multiple behaviors such as law-breaking activities, threatening to others, intentional self-injury, physically and verbally aggressive towards staff, and assaultive behavior of a third-degree (Recklessly inflicting fear of serious bodily harm, or recklessly causing fear of injury with a deadly weapon). Assessment showed that Resident 2 was admitted to the [redacted] health facility after they robbed a man and beat them up with their fists. The assessment showed "An individual accepted by a contracted long-term care provider may pose risks to themselves, other residents, caregivers or others outside the facility/home."

Review of Resident 2's negotiated care plan (NCP), dated 01/20/2023, showed they had multiple behaviors, including being assaultive and hearing voice commands to hurt others.

Review of hospital records after Resident 1's second hospitalization dated 03/23/2023, showed Resident 1 sustained multiple left-side facial fractures (a partial or complete break in a bone resulting from the application of excessive force) and a traumatic subdural hemorrhage (a head trauma that caused a collection of blood outside the brain). Hospital record review showed Resident 1 underwent an incision and drainage (a minor surgical procedure to release the pus or pressure built up under the skin) surgical procedure to their left ear because of a contusion (a bruise).

In an interview on 06/27/2023 at 3:55 PM, Staff A stated that on the night of the second incident, staff on duty checked Resident 1 and Resident 2 to ensure they were both asleep before they went to bed themselves. Staff A stated that they did not monitor both residents that night of the incident to protect Resident 1 from getting assaulted by Resident 2.

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, CARING ANGELS ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 7/13/2023

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

S. Njoroge
Provider (or Representative)

7/7/2023
Date