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

06/09/2025

AMANI ADULT FAMILY HOME INCORPORATED
AMANI ADULT FAMILY HOME
1635 S 264TH PLACE
DES MOINES, WA 98198

RE: AMANI ADULT FAMILY HOME # 752410

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 59664 (Completion Date 06/09/2025) and 55663 (Completion Date 03/12/2025).

The Department completed a follow-up inspection of your Adult Family Home on 06/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-76-10350 Assessment Updates required.

(2) The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

(d) At least every 12 months.

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(4) At least every twelve months.

WAC 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(1) In locked storage;

WAC 388-76-10616 Resident rights Transfer and discharge notice.

(1) Before a home transfers or discharges a resident, the home must give the resident and the resident's representative a written thirty day notification informing them of the transfer or discharge. The home must also make a reasonable effort to notify, if known, any interested family member. The written notification must be in a language and manner the resident understands and include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location where the resident is transferred or discharged if known at the time of the thirty-day discharge notice;

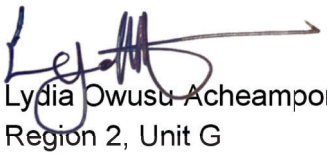
(d) The name, address, and telephone number of the state long-term care ombuds;

(3) A copy of the written notification must be in the resident's records.

The Department staff who did the On Site verification:
Michele Grumke, AFH Licensor

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

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

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 the unannounced on-site full inspection on 02/28/2025 of:
AMANI ADULT FAMILY HOME
1635 S 264TH PLACE
DES MOINES, WA 98198

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Michele Grumke, AFH Licensor

From:
DSHS, Aging and Long-Term Support 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.

Dahl Kim
Residential Care Services

03/12/2025
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.

Provider (or Representative)

4/05/25
Date

WAC 388-76-10350 Assessment Updates required.

(2) The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

(d) At least every 12 months.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to review and update 1 of 2 resident (Resident 2) Assessment at least every 12 months. This failure placed Resident 2 at risk of unmet care needs.

Findings included...

During a visit on 02/28/2025 at 8:20 AM, observation showed Resident 2 lived in and received care from the AFH.

A review of Resident 2's records showed Resident 2 was admitted to the AFH on [redacted]/2013. Further review showed Resident 2's Assessment was dated 07/14/2023.

A review of the departments Comprehensive Assessment Reporting and Evaluation (CARE) showed a Service Episode Report (SER) dated 06/27/2024 that Resident 2 was currently denied financial eligibility. Further review showed Resident 2 had not received Long-Term Care (LTC) services since 12/2023.

In an interview on 02/28/2025 at 10:24 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 2 had previously been receiving LTC services through the

state. Staff A further stated that Resident 2 no longer met the financial eligibility requirements to receive services through the state. In addition, Staff A stated that Resident 2 was under guardianship and payment for care was provided by the guardian.

In an interview on 02/28/2025 at 3:00 PM, Staff A stated that Resident 2's Assessment dated 07/14/2023 was the resident's most current assessment. Staff A further stated that resident assessments were to be completed when a significant change occurred. In addition, Staff A stated that they would contact Resident 2's guardianship service and arrange for an assessment to be completed.

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, AMANI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4/30/24 .

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

Provider (or Representative) 4/05/25 Date

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(4) At least every twelve months.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the Negotiated Care Plan (NCP) for 1 of 2 sampled residents (Resident 2) was reviewed at least every twelve months. This failure placed Resident 2 at risk of unmet care needs.

Findings included...

During a visit on 02/28/2025 at 8:20 AM, observation showed Resident 2 lived in and received care from the AFH.

A review of Resident 2's NCP updated on 03/12/2020 showed Resident 2 was admitted

to the AFH on [redacted]/2013. Further review showed Resident 2's NCP was last signed and dated by the AFH on 04/20/2022 and by Resident 2's Representative on 04/26/2022.

In an interview on 02/28/2025 at 2:07 PM, Staff A, Entity Representative/Resident Manager, confirmed that Resident 2's current NCP was the updated 03/12/2020 NCP. Staff A further stated that they would send Resident 2's NCP to their Guardian for their review.

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, AMANI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4/5/2025 .

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

Provider (or Representative) — Date: 4/05/25

WAC 388-76-10455 Medication Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is:

(2) By nurse delegation per WAC 246-840-910 through 246-840-970 ; unless

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to have nurse delegation (a state program that allows nursing assistants working in certain settings, like AFH, to perform certain tasks, like administration of prescribed medicines, normally performed only by licensed nurses), in place for 1 of 2 sampled residents (Resident 2). This failure placed Resident 2 at risk of worsening of condition.

Findings included...

During a visit on 02/28/2025 at 8:20 AM, observation showed Resident 2 lived in and received medication assistance from the AFH.

A review of Resident 2's February 2025 pharmacy generated Medication Administration Record (MAR) showed Resident 2 was prescribed,

-Vitamin A & D Ointment, apply to affected area daily at bedtime (treats and prevents rash). Further review showed initialed entries from 02/01/2025-02/27/2025 for 8:00 PM.

-Hydrocortisone 1 percent (%) Cream, apply 5 grams topically to legs twice daily (treats inflammation, rash, and itchiness). Further review showed initialed entries from 02/01/2025-02/27/2025 for 8:00 AM and 8:00 PM.

In an interview on 02/28/2025 at 10:24 AM, Staff A, Entity Representative/Resident Manager, stated that Resident 2 was nurse delegated for topical medications that they applied.

In an interview on 02/28/2025 at 4:50 PM during the exit, Staff A stated that they would send Resident 2's nurse delegation paperwork to the department.

A review of an email correspondence received by the department on 03/06/2025 at 4:48 PM from Staff A showed, Resident 2's guardianship service had been contacted to sign a consent for nurse delegation services for Resident 2.

In an interview on 03/07/2025 at 11:46 AM, Collateral Contact 1 (CC1) stated that they had not performed nurse delegation services for Resident 2.

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, AMANI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4/30/25 .

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

Provider (or Representative) _____ Date 4/05/25

WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored:

(1) In locked storage;

This requirement was not met as evidenced by:

Based on observation and interview, the Adult Family Home (AFH) failed to keep resident medication in locked storage. This failure placed all ambulatory residents (Residents 1, 2, and 3) at risk of accessing and taking medication not prescribed for their use.

Findings included...

During a visit on 02/28/2025 at 8:20 AM, observation showed Residents 1, 2, and 3 lived in and received medication assistance from the AFH. Further observation showed Resident 1 ambulated independently with the use of a walker, Resident 2 required no assistive devise to ambulate independently, and Resident 3 ambulated independently with the use of a cane.

Observation on 02/28/2025 at 8:23 AM showed, Resident 3 ambulated independently from their bedroom to the family room with the use of a cane.

Observation on 02/28/2025 at 8:24 AM showed, a cabinet located in the dining room with two sets of cupboards, one on top and another on the bottom. Further observation showed the bottom cupboards contained resident medication and was unlocked.

Observation on 02/28/2025 at 8:25 AM showed, Resident 1 ambulated independently with the use of a walker from the hallway to the family room.

In an interview on 02/28/2025 at 8:26 AM, Staff A, Entity Representative/Resident Manager, stated that they had forgotten to lock the medication storage cabinet. Staff A was observed locking the medication cabinet with a childproof lock. The plastic childproof lock had 2 long pieces of plastic, one that went inside the handles of the cabinet and the other on the outside of the handles. The lock had a tab on the top and bottom that when pressed, could be threaded into the two long pieces, and locked.

Observation on 02/28/2025 at 8:39 AM showed, Staff A opened the medication storage cabinet, retrieved Resident 3's medication, and left the cabinet unlocked. Observation further showed Staff A took the medication into the kitchen, out of line of sight of the cabinet, and prepared Resident 3's medication. In addition, Resident 3 was seated at the dining room table eating breakfast, directly in front of the unlocked medication storage cabinet along with their family member who was taking Resident 3 to an appointment.

In an interview on 02/28/2025 at 8:40 AM, Staff A stated that they had just opened the medication cabinet.

Observation on 02/28/2025 at 8:44 AM showed, Staff A retrieved a blood pressure cuff from the medication cabinet, left the medication cabinet unlocked, and went to

Resident 2's bedroom to take their blood pressure.

Observation on 02/28/2025 at 8:45 AM showed, 2 plastic bags with 4 brown paper bags with resident medication inside, on the sofa in the living room. Further observation showed the sofa was across from the dining table where Resident 3 was eating breakfast. Observation further showed Staff A had not been within line of sight of the medication.

In an interview on 02/28/2025 at 8:46 AM, Staff A stated that the bags contained the resident's March 2025 medication. Staff A further stated that the bags had been delivered last night and placed in locked storage. In addition, Staff A stated that they had removed the bags from storage to sort the resident's medication earlier in the morning.

Observation on 02/28/2025 at 8:53 AM showed, Staff A removed Resident 1's medication from the medication storage cabinet, reviewed the resident's bubble packs, and punched the resident's medication from the bubble pack into a medication cup. Further observation showed Staff A returned Resident 1's medication to the medication storage cabinet, left it unlocked, placed Resident 1's medication cup on their breakfast tray that was on the kitchen table, and walked down a hallway. Staff A was not observed reviewing Resident 1 Medication Administration Record (MAR) while preparing the resident's medication, was not within line of sight of Resident 1's medication on their breakfast tray, and did not watch Resident 1 take their medication.

Observation on 02/28/2025 at 8:58 AM showed, Staff A removed Resident 2's medication from the medication storage cabinet, reviewed the bubble packs, and punched medication into medication cups. Staff A was not observed reviewing Resident 2's MAR while preparing the resident's medication.

Observation on 02/28/2025 at 9:03 AM showed, Resident 2 had ambulated independently from their bedroom to the dining room table. Further observation showed Staff A placed Resident 2's breakfast tray in front of the resident with a medication cup on it and walked away. In addition, Staff A did not observe Resident 2 to ensure they took their medication.

In an interview on 02/28/2025 at 9:04 AM, Staff A stated that they had watched the residents take their medications before and it had never been an issue. Staff A further stated that they trusted the residents to take their medication. In addition, Staff A stated that they did not need to check the residents MAR when providing medication. Staff A stated that when medication was received by the AFH, Staff A checked the medication and resident MAR to ensure they both matched.

In an interview on 02/28/2025 at 9:21 AM, Staff A stated that they provided all the residents with their morning medication and then initialed the residents MARs.

Observation on 02/28/2025 at 10:05 AM showed, Staff A removed Resident 4's medication from the medication storage cabinet, reviewed the bubble packs, and punched medication into a medication cup. Observation further showed Staff A put Resident 4's medication back in the medication storage cabinet, closed the door, and left the cabinet unlocked. Observation showed Staff A walked to Resident 4's bedroom to assist the resident with their medication, out of line of sight of the unlocked medication storage cabinet. In addition, observation showed Resident 1 and Resident 2 were seated in the family room watching TV with the medication storage cabinet unlocked in the dining room.

In an interview on 02/28/2025 at 10:07 AM, Staff A stated that they were sorry for leaving the medication storage cabinet unlocked.

Observation on 02/28/2025 at 11:13 AM showed, the top cupboards of the medication storage cabinet was accessible and when opened, the medication below on the lower shelves was accessible.

In an interview on 02/28/2025 at 11:15 AM, Staff A stated that they had wanted to fix the medication storage cabinet.

Observation on 02/28/2025 at 3:25 PM showed, Staff A removed Resident 3's medication from the locked medication cabinet in the kitchen, reviewed the resident's bubble pack, and punched medication from the bubble pack into a medication cup. Further observation showed Resident 3 was seated at the kitchen table enjoying a snack. Observation further showed Staff A filled a glass of water and placed it in front of Resident 3. In addition, observation showed Staff A placed Resident 3's medication cup on the counter and stated," Resident 3 has not finished their pudding." Staff A then left the kitchen, walked down the hallway into Resident 2's bedroom, out of line of sight of Resident 3's medication cup and with Resident 1 seated in the family room.

In an interview on 02/28/2025 at 3:27 PM, Staff A stated that they had left Resident 3's medication on the counter and there was nobody else here.

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, AMANI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4/30/25 .

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

Provider (or Representative) | Date 4/05/25

WAC 388-76-10616 Resident rights Transfer and discharge notice.

(1) Before a home transfers or discharges a resident, the home must give the resident and the resident's representative a written thirty day notification informing them of the transfer or discharge. The home must also make a reasonable effort to notify, if known, any interested family member. The written notification must be in a language and manner the resident understands and include the following:

(a) The reason for transfer or discharge;

(b) The effective date of transfer or discharge;

(c) The location where the resident is transferred or discharged if known at the time of the thirty-day discharge notice;

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

(3) A copy of the written notification must be in the resident's records.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to provide to 1 of 1 resident (Resident 1) a written 30-day notification of discharge that included the reason, date, and location as well as the name, address, and phone number for the state long-term care ombuds, and kept a copy in Resident 1's records. This failure denied Resident 1's the ability to make informed decisions and affected their quality of life.

Findings included...

During a visit on 02/28/2025 at 8:20 AM, observation showed Resident 1 lived in and received care from the AFH.

In an interview on 02/28/2025 at 8:30 AM, Resident 1 stated that on Tuesday

[02/25/2025], their belongings had been placed near the front door. Resident 1 further stated that a young man, whom they did not know, arrived at the AFH to collect Resident 1's belongings and pick up the resident. In addition, Resident 1 stated that they had refused to leave and had not received an eviction notice.

A review of Resident 1's records showed Resident 1 was admitted to the AFH on [redacted]/2024. Further review showed no discharge notice in Resident 1's records.

In an interview on 02/28/2025 at 10:24 AM, Staff A, Entity Representative/Resident Manager, stated that they had called Resident 1's Case Manager (CM) and informed them that they wanted Resident 1 to live elsewhere. Staff A further stated that Resident 1's CM told them not to worry about it and they would take care of it. In addition, Staff A stated that they thought if they told Resident 1's CM that was enough. Staff A stated that they did not realize they still needed to provide Resident 1 with a discharge notice. Staff A further stated that Resident 1 made accusations of theft, had called the police, thrown food, used offensive language, refused to shower, and was verbally abusive.

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, AMANI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 4/30/25 .

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

Provider (or Representative) _____ Date 4/05/25