STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
***6639 Capitol Blvd SW, Floor 1, Tumwater, WA 98501***

Heavenly Acres AFH, Inc

Heavenly Acres AFH, Inc
27204 76th Ave E
Graham, WA 98338

RE: Heavenly Acres AFH, Inc License # 752715

Dear Provider:

This letter addresses Compliance Determination(s) 40354 (Completion Date 04/25/2024) and 37061 (Completion Date 03/12/2024).

The Department completed a follow-up inspection of your Adult Family Home on 04/25/2024 and found that you have corrected the violations listed in the Complaint report dated 03/12/2024. Your home is back in compliance as of 03/25/2024 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 388-76-10670-4, WAC 388-76-10673-1, WAC 388-76-10673-1-a, WAC 388-76-10673-2, WAC 388-76-10673-2-a, WAC 388-76-10673-2-b, WAC 388-76-10673

The Department staff who did the on-site verification:
Jonel Tuckett, AFH Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit G
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** Heavenly Acres AFH, Inc
**Provider Type:** Adult Family Home
**License/Cert.#:** 752715
**Compliance Determination #:** 37061
**Intake ID:** 117032
**Investigator:** Jonel Tuckett
**Region/Unit #:** RCS Region 3 / Unit G
**Investigation Date(s):** 02/21/2024 through 03/12/2024
**Complainant Contact Date(s):** 03/12/2024

**Allegation(s):**
Quality of Care/Treatment-

Adult Family Home (AFH) Caregivers suspected that Resident 6 (R6) physically abused Resident 5 (R5) several times over the last four months.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 4<br>Resident sample size: 2<br>Closed records sample size: 2 |
| **Observations:** | Caregiver to Resident interactions, care and services, environment, and safety measures. |
| **Interviews:** | AFH Residents, AFH Caregivers, AFH Provider, Healthcare Providers, Other. |
| **Record Reviews:** | Resident Assessments, Negotiated Care Plans (NCP), AFH Email Records, AFH Incident Log, Hospital Records, Incident Investigation Photos, Department Records. |

**Investigation Summary:**
Quality of Care/Treatment-

Observation, interview, and record review showed that the facility failed to protect each resident who is an alleged victim of physical abuse and prevent future potential harm for 1 of 6 residents, R5. This failure resulted in R5 being at risk for further potential physical abuse. Failed practice was cited.

Observation, interview, and record review showed that the facility failed to report suspected physical abuse to the Department and to the appropriate law enforcement agency for 1 of 6 residents, R5. This failure resulted in a delay in the Department and law enforcement being able to investigate claims of physical abuse and placed R5 at risk for ongoing physical abuse. Failed practice was cited.

**Conclusion / Action:**

☒ 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 #: 752715 | Compliance Determination # 37061 |
| Plan of Correction | Heavenly Acres AFH, Inc | Completion Date |
| Page 1 of 7 | Licensee: Heavenly Acres AFH, Inc | 03/12/2024 |

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 02/21/2024 and 02/21/2024 of:

Heavenly Acres AFH, Inc
27204 76th Ave E
Graham, WA 98338

This document references the following complaint number(s): 117032

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

The department staff that investigated the Adult Family Home:

Jonel Tuckett, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit G
6639 Capitol Blvd SW, Floor 1
Tumwater, WA 98501

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.

Jennifer LeMaster
Residential Care Services

03/22/2024
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)

3/25/24
Date

(1) **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 facility failed to protect each resident who is an alleged victim of physical abuse and prevent future potential harm for 1 of 6 residents (Resident 5 [R5]). This failure resulted in R5 being at risk for further potential physical abuse.

Findings included...

A record review on 02/22/2024 at 4:31 pm of R5's Assessment dated 04/27/2023 showed that R5 had a diagnosis of [redacted], was underweight, and was bed-bound.

A record review on 02/20/2024 at 4:51 pm of Resident 6 (R6)'s Assessment dated 08/04/2023 showed that R6 would complain about every roommate they had and spoke negatively about their current roommate while the roommate was in the room.

An observation on 02/21/2024 at 10:16 am showed that R5 and R6 had been roommates and their beds were adjacent to and in close proximity of each other.

During an interview on 02/21/2024 at 10:43 am, the Resident Manager (RM) stated that the AFH called R6's mental health doctor in January 2024 requesting a medication change and reported that R6 was constantly saying that they would harm R5, and that R5 was very frail and an easy target. RM stated that on 01/17/2024 at 6:00 am, RM found R5 and R6 on the floor in their room, both with bumps and bruises, yelling, and appeared to have been fighting. RM stated that the caregivers had been finding bruises of unknown origin on R5's arms, wrists, neck, and forehead for about two weeks prior to the incident on 01/17/2024. RM stated that they took pictures of R5's bruises and reported to the AFH Provider that they suspected that R6 was physically harming R5 at night and wanted to separate R5 and R6, but the Provider told RM to set a floor alarm, there was no proof, and it could be anything. RM stated that they set the floor alarm and caught R6 heading to R5's bed at night at least twice and continued to find bruising of unknown origin on R5 and updated the Provider. RM stated that they used the floor alarm and put wheelchairs and walkers between R5's bed and R6's bed so that R6 could not get to R5 easily, but R6 was still setting off the floor alarm and they continued to find bruises on R5. RM stated that they

still wanted to separate R5 and R6, but the Provider just wanted the floor alarm and told RM there was no proof that R6 was harming R5. RM stated that R6 had appointments with their mental health doctor on 01/18/2024 and 01/29/2024 and told the doctor during those appointments that they had been harming R5.

A record review on 02/21/2024 at 10:43 am of pictures that RM took of R5's injuries of unknown origin showed bruising to R5's forehead, neck, wrists and forearms. RM stated that they did not have the dates of the pictures but estimated that they were taken around 01/03/2024, two weeks prior to when R5 and R6 were found on the floor in their room on 01/17/2024.

During an interview on 02/21/2024 at 10:05 am, RM stated that R6 was admitted to the hospital for psychiatric (mental health) issues on [redacted]/2024 and would admit to the Provider's other home upon discharge from the hospital.

During an interview on 02/29/2024 at 10:05 am, when asked what the AFH did to keep R5 safe from continued harm from R6, the Provider stated that all of the rooms in their other homes were full, so they did not have anywhere to move R5 or R6 to. The night caregivers would hear the floor alarm and respond to it. The Provider stated that R6 should be discharging from the hospital on [redacted]/2024 and would admit to the Provider's other home, House 1.

During an interview on 02/29/2024 at 10:08 am, the Provider stated that staff had suspected possible abuse of R5 by R6 and mentioned it to the Provider when the bruising started, before they found R5 and R6 on the floor, but it was all speculation at that point.

A record review on 02/22/2024 at 5:54 pm of the AFH Abuse Policy dated 01/01/2016 showed that the AFH did not allow abuse of any resident, trains staff to report possible abuse as required in chapter 74-34 Revised Code of Washington (RCW), and will not interfere with the requirement that employees and other mandated reporters file reports directly with the Department if they suspect physical abuse to have occurred.

A record review of AFH Incident Log on 03/07/2024 at 10:00 am showed that the AFH was aware of safety concerns for R5 from R6 for 29 days before the Provider took action to separate R5 and R6 as roommates:

- 01/02/2024-Provider documented that they were told by R6's doctor that R6 wanted to kill R5 and R5 kept R6 up all night.
- 01/17/2024-R6 disturbing R5 at 3:00 am. R5 and R6 found on their floor at 6:00 am, yelling and appeared to have been fighting. R6 did not answer what happened. R5 stated that they did not know why R6 was so mean to them.
- 01/18/2024-AFH reported concerns to R5's POA that R6 implied they wanted to harm R5. Doctor reporting to [redacted]. Floor alarms and frequent checks

by staff.

• 01/23/2024-RM found R6 standing at R5's bed at 2:20 am after the floor alarm activated. R5 was sound asleep. R6 did not answer why they were there.

• 01/29/2024-R6 told their doctor that they had been harming R5 and was admitted to the hospital.

**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, Heavenly Acres AFH, Inc is or will be in compliance with this law and / or regulation on (Date) 3/25/24.

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

Provider (or Representative) — Date: 3/29/24

(2)

**WAC 388-76-10673 Abuse and neglect reporting Mandated reporting to department Required.**

(1) In accordance with chapter 74.34 RCW, all providers, entity representatives, resident managers, owners, caregivers, staff, and students that provide care and services to residents, are mandated reporters and must immediately report to the department when there is:

(a) A reasonable cause to believe that abandonment, abuse, exploitation, financial exploitation, or neglect of a vulnerable adult has occurred; or

(2) Reports must be made to:

(a) The centralized toll free telephone number provided by the department; and

(b) The appropriate law enforcement agencies, as required under chapter 74.34 RCW.

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

Based on observation, interview, and record review, the facility failed to report suspected physical abuse to the Department and to the appropriate law enforcement agency for 1 of 6 residents (Resident 5 [R5]). This failure resulted in a delay in the Department and law enforcement being able to investigate claims of physical abuse and placed R5 at risk for ongoing physical abuse.

Findings included...

A record review on 03/11/2024 at 11:06 am of the Revised Code of Washington (RCW) 74.34.035 dated 2003 showed that when there is reasonable cause to believe that abuse of

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a vulnerable adult has occurred, mandated reporters shall immediately report to the Department. Mandated reporters must also report to a law enforcement agency if the injury appears on the face or neck, and when there is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults.

A record review on 02/22/2024 at 4:31 pm of R5's Assessment dated 04/27/2023 showed that R5 had a diagnosis of [redacted] ([redacted]), was underweight, and was bed-bound.

A record review on 02/20/2024 at 4:51 pm of Resident 6 (R6)'s Assessment dated 08/04/2023 showed that R6 would complain about every roommate they had and spoke negatively about their current roommate while the roommate was in the room.

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During an interview on 02/21/2024 at 10:43 am, the Resident Manager (RM) stated that the AFH called R6's mental health doctor in January 2024 requesting a medication change and reported that R6 was constantly saying that they would harm R5 and that R5 was very frail and an easy target. RM stated that on 01/17/2024 at 6:00 am, RM found R5 and R6 on the floor in their room with bumps and bruises, yelling, and appeared to have been fighting. RM stated that the caregivers had been finding bruises of unknown origin on R5's arms, wrists, neck, and forehead for about two weeks prior to the incident on 01/17/2024. RM stated that they took pictures and reported to the AFH Provider that they suspected that R6 was physically harming R5 at night and wanted to separate R5 and R6, but the Provider told RM to set a floor alarm, there was no proof, and it could be anything. RM stated that they set the floor alarms and caught R6 heading to R5's bed at night at least twice and continued to find bruising of unknown origin on R5 and updated the Provider. RM stated that they reported the suspected abuse to R5's doctor and son/POA (legal representative) and R6's mental health doctor. RM stated that they wanted to report to the Department but the Provider and other caregivers felt that RM was overreacting, had no proof, and convinced R5 to second guess themselves and not make a report. RM stated that R5's doctor reported to [redacted] ([redacted]), so the AFH did not need to. RM stated that R6 had appointments with their mental health doctor on 01/18/2024 and 01/29/2024 and told the doctor during those appointments that they had been harming R5.

A record review on 02/21/2024 at 10:43 am of pictures that RM took of R5's injuries of unknown origin showed bruising to R5's forehead, neck, wrists and forearms. RM stated that they did not have the dates of the pictures but estimated that they were taken around 01/03/2024, two weeks prior to when R5 and R6 were found on the floor in their room on 01/17/2024.

A record review of an Email sent from the Provider on 02/22/224 at 5:08 pm showed that the Provider stated that there was no excuse for failing to report the suspected abuse, that they regretted not taking the situation more seriously, and that they would take these

things more seriously regardless from now on.

During an interview on 02/29/2024 at 10:08 am, the Provider stated that staff had suspected possible abuse of R5 by R6 and mentioned it to the Provider when the bruising started, before they found R5 and R6 on the floor, but it was all speculation at that point. The Provider stated that they did not report the suspected abuse because they didn't think they needed to since the doctor had already reported it.

A record review on 02/22/2024 at 5:54 pm of the AFH Abuse Policy dated 01/01/2016 showed that the AFH did not allow abuse of any resident, trains staff to report possible abuse as required in chapter 74-34 RCW, and will not interfere with the requirement that employees and other mandated reporters file reports directly with the Department if they suspect physical abuse to have occurred.

A review of Department records on 02/20/2024 at 4:53 pm showed that the AFH had not reported suspected physical abuse of R5 to the Department.

A record review of AFH Incident Log on 03/07/2024 at 10:00 am showed that the AFH was aware of suspected physical abuse of R5 by R6 for at least 29 days and did not report to the Department or law enforcement:

- 01/02/2024-Provider documented that they were told by R6's doctor that R6 wanted to kill R5 and R5 kept R6 up all night.
- 01/17/2024-R6 disturbing R5 at 3:00 am. R5 and R6 found on their floor at 6:00 am, yelling and appeared to have been fighting. R6 did not answer what happened. R5 stated that they did not know why R6 was so mean to them.
- 01/18/2024-AFH reported concerns to R5's POA that R6 implied they wanted to harm R5. Doctor reporting to [redacted] Floor alarms and frequent checks by staff.
- 01/23/2024-RM found R6 standing at R5's bed at 2:20 am after the floor alarm activated. R5 was sound asleep. R6 did not answer why they were there.
- 01/29/2024-R6 told their doctor that they had been harming R5 and was admitted to the hospital.

**Attestation Statement**

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

Provider (or Representative)

3/29/24
Date



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