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

Absolute Love and Care Adult Family Home LLC
ABSOLUTE LOVE AND CARE ADULT FAMILY HOME LLC
11903 SE 206TH ST
KENT, WA 98031

RE: ABSOLUTE LOVE AND CARE ADULT FAMILY HOME LLC License # 752777

Dear Provider:

This letter addresses Compliance Determination(s) 35456 (Completion Date 02/13/2024) and 33556 (Completion Date 12/28/2023).

The Department completed a follow-up inspection of your Adult Family Home on 02/13/2024 and found that you have corrected the violations listed in the Complaint report dated 12/28/2023. Your home is back in compliance as of 01/01/2024 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 388-76-10400-3-b, WAC 388-76-10220-3, WAC 388-76-10355-1, WAC 388-76-10355-2, WAC 388-76-10355-3

The Department staff who did the on-site verification:
Kirsten Biddle, AFH Licensor

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: ABSOLUTE LOVE AND CARE ADULT FAMILY HOME LLC
License/Cert.#: 752777
Compliance Determination #: 33556
Investigator: Lyra Ouano
Provider Type: Adult Family Home
Intake ID: 107965
Region/Unit #: RCS Region 2 / Unit E
Investigation Date(s): 12/06/2023 through 12/28/2023
Complainant Contact Date(s): 12/04/2023

Allegation(s):
The Named Resident (NR) was found with bruise on their hand to elbow, NR reported they had a fall with injury to their arm and leg, and the Adult Family Home (AFH) did not report the incident to their Case Manager (CM)

Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 2 Closed records sample size: 0
Observations:	General Adult Family Home (AFH) environment Staff/resident interactions Resident/resident interactions NR demeanor NR Physical appearance
Interviews:	NR AFH Staff AFH residents Entity Representative (ER)
Record Reviews:	NR Negotiated Care Plan (NCP) NR Assessment Progress notes Incident log Staff Background checks Abuse and Neglect policy

Investigation Summary:
Observation, interview, and record review showed NR, two residents, one household member being cared for in the home. NR was found with a bruise to the right pointer finger and to their left hip. In an interview, NR said that they fell during the nighttime hours and hit their left hip on a walker that was on the floor. NR said that they also fell another time in the home causing a bruise to their right index finger. NR and another resident said that they did not have any care and services concern and felt safe in the home. In an interview, staff said that they were not aware of NR's skin condition and

falls. Record review showed there was no incident log found for NR's skin condition and presumed falls. NR's skin condition was not reported to their CM, doctor, and family. Failed practice identified. See Statement of Deficiency dated 12/28/2023. WAC 388-76-10355 Negotiated Care Plan, WAC 388-76-10400 Care and services, WAC 388-76-10220 Incident Log.

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

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 an unannounced on-site complaint investigation on 12/06/2023 and 12/06/2023 of:

ABSOLUTE LOVE AND CARE ADULT FAMILY HOME LLC
11903 SE 206TH ST
KENT, WA 98031

This document references the following complaint number(s): 107965

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 investigated the Adult Family Home:

Lyra Ouano, AFH Licensor

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

12/29/2023
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) Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(3) The care and services in a manner and in an environment that:

(b) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review the adult family home (AFH) failed to provide the necessary care and services of having an awake staff at night for 1 of 1 resident (Resident 1). In addition, the AFH failed to ensure Resident 1 had their calling device within reach. This failure placed the resident at risk of harm in the event the resident required assistance at night and there was no calling device to alert AFH staff.

Findings included....

On 12/06/2023 at 3:10 PM, observation showed three residents and one Household Member (HM) being cared for in the AFH by Staff B, Caregiver. Staff A, Entity Representative, came from the lower-level private area of the home at 3:15 PM.

In an interview on 12/06/2023 at 3:15 PM, Staff A said that there was no incident that had happened in the home within the last three months. Staff A said that Resident 1's Collateral Contact (CC) reported to them Resident 1 had bruising on their left hand, right before Thanksgiving Day (meaning 11/23/2023). Staff A said that the bruising was on Resident 1's left pointer finger. Staff A said that they thought the bruising was not there anymore. Staff A said that they checked the residents' skin during shower days. Staff A said that they did not document the residents' skin check they performed. Staff A said other residents did not have any wounds or skin issues except Resident 2, HM.

On 12/06/2023 at 3:30 PM interview, Staff B said that they observed Resident 1 with a bruise on their left hip, one to two weeks ago and reported it to Staff A to document. Staff B said that Resident 1 reported to them that they fell during the nighttime hours. Staff B added that they worked during the daytime hours and Staff A was the one working at nighttime.

On 12/06/2023 at 3:33 PM, observation showed Resident 1 lying in bed, awake, and alert. A commode was observed six inches from the edge and at the right side toward the foot of the bed. A walker was observed six inches away behind the commode. A calling device was not observed anywhere in the bedroom.

On 12/06/2023 at 3:35 PM, the department staff with Staff A observed Resident 1's left hip had three point five inches in diameter skin area that was hard to touch. This skin area had an elevation of three point seventy-five inches. This skin area was pale red violet in color. There was a one-fourth inch line open skin area at the top of the skin that was dry and had a scab on the edges. Around this skin area was dark purple, brown, and had yellow edges that measured eight point five inches long and six point five inches wide. Below this skin area to the left close to the buttock fold was another skin discoloration of purple to brown and had yellow edges measuring four point five inches long and one point five inches wide. There was no skin discoloration in Resident 1's left hand or pointer finger. There was a one-millimeter black round spot on Resident 1's right pointer fingernail bed close to the cuticle.

In an interview on 12/06/2023 at 3:35 PM Staff A said that they had not seen the skin discoloration and hard skin on Resident 1's left hip prior to 12/06/2023. Staff A said that Staff B did not report to them that Resident 1 had skin issue and was not aware Resident 1 had a fall. Staff A said that their bedroom was below Resident 1's in the lower level, and they could hear the resident when they transferred to bedside commode at nighttime. Staff A said that they oversaw the residents at nighttime and did not hear Resident 1 fell. When asked if a doctor had looked at Resident 1's skin issue, Staff A said that Resident 1's doctor was coming on Friday, 12/08/2023. When asked if they reported the fall incident and skin discoloration to Resident 1's doctor, Staff A said they had not.

In an interview on 12/06/2023 at 3:45 PM, Resident 1 said that they did not know where their calling device was and that they used the commode at night on their own. At this same time, Resident 1 demonstrated getting up from the bed to use the commode. The resident was able to sit at the edge of the bed. Resident 1 said, "I don't feel well right now. I feel lightheaded". Resident 1 said that a week ago (meaning the week of November 27, 2023) they fell at night and hit their left hip on a walker that was on the floor. Resident 1 said that they could not turn to their left side in bed because their left hip hurt. Resident 1 said that they reported to Staff B their fall incident the following day while Staff B saw their left hip bruise.

On 12/06/2023 at 4:25 PM, Staff A said that Resident 1 and other residents had calling devices attached to a green lanyard within easy reach to them. At this same time, Staff A looked for Resident 1's calling device in drawers and around the bedside table. Staff A could not locate the calling device in Resident 1's bedroom.
In an interview on 12/06/2023 at 4:30 PM, Staff B said that Resident 1 knew how to use the calling device and they had not seen Resident 1's calling device that day. Staff A said that Resident 1 placed their calling device in drawers and misplaced it in the past.

Review of Resident 1's assessment dated 11/08/2023 safety section showed that the resident, "Has fainting spells, gets dizzy every time they stand up, had broken their hips twice from falling and always needs someone present when getting up". This section showed that a caregiver was always present when Resident 1 was getting up. The locomotion in room and immediate living environment section showed that Resident 1 required extensive assistance with one person assistance. This section showed that the

caregivers had to keep assistive device (walker) within reach, and when using the walker, the caregivers had to direct the walker and keep caregiver's hands on the resident. In the transfer section, Resident 1 required extensive assistance, physical assist with completing transfers, and monitor resident while the resident transfers. Also, the caregivers need to assist Resident 1 with a boost to stand up and guide to sit down. The toilet use section showed Resident 1 required extensive assistance with one-person physical assist. The skin care section showed the caregivers to complete weekly skin checks during showers and as needed.

Record review of Resident 1's Negotiated Care Plan (NCP) dated 03/01/2023 showed on page five, "Caregivers gives Resident a call button within reach, helps them to and from commode", and that the caregivers checked Resident 1 four times at nighttime.

The AFH failed to ensure Resident 1 had a calling device within reach to alert the staff they needed assistance to use the commode. The walker was not within reach of the resident, and the resident fell at nighttime suffered a skin condition without Staff A's knowledge. There was no documentation that AFH staff rounded on residents to ensure residents had their calling device and safety. There was no documentation that the night staff checked on Resident 1 four times at nighttime. There was no documentation that AFH staff performed the necessary skin check and monitoring system of Resident 1's skin condition. The AFH failed to have Resident 1 evaluated by a medical professional following the fall with skin injury.

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, ABSOLUTE LOVE AND CARE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 1-1-24

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

Ehm Doton — 1-10-24

Provider (or Representative) — Date

WAC 388-76-10220 Incident log. The adult family home must keep a log of:

(3) Any injury to a resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the home kept a log of suspected falls and skin trauma for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 at high risk for repeated incidents and no system to track it.

caregivers had to keep assistive device (walker) within reach, and when using the walker, the caregivers had to direct the walker and keep caregiver's hands on the resident. In the transfer section, Resident 1 required extensive assistance, physical assist with completing transfers, and monitor resident while the resident transfers. Also, the caregivers need to assist Resident 1 with a boost to stand up and guide to sit down. The toilet use section showed Resident 1 required extensive assistance with one-person physical assist. The skin care section showed the caregivers to complete weekly skin checks during showers and as needed.

Record review of Resident 1's Negotiated Care Plan (NCP) dated 03/01/2023 showed on page five, "Caregivers gives Resident a call button within reach, helps them to and from commode", and that the caregivers checked Resident 1 four times at nighttime.

The AFH failed to ensure Resident 1 had a calling device within reach to alert the staff they needed assistance to use the commode. The walker was not within reach of the resident, and the resident fell at nighttime suffered a skin condition without Staff A's knowledge. There was no documentation that AFH staff rounded on residents to ensure residents had their calling device and safety. There was no documentation that the night staff checked on Resident 1 four times at nighttime. There was no documentation that AFH staff performed the necessary skin check and monitoring system of Resident 1's skin condition. The AFH failed to have Resident 1 evaluated by a medical professional following the fall with skin injury.

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) Date

WAC 388-76-10220 Incident log. The adult family home must keep a log of:

(3) Any injury to a resident.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure the home kept a log of suspected falls and skin trauma for 1 of 1 resident (Resident 1). This failure resulted in Resident 1 at high risk for repeated incidents and no system to track it.

Findings included...

On 12/06/2023 at 3:10 PM, observation showed three residents and one Household Member (HM) being cared for in the AFH by Staff B, Caregiver. Staff A, Entity Representative arrived at the home at 3:15 PM.

In an interview on 12/06/2023 at 3:15 PM, Staff A said that there was no incident that happened in the home within the last three months. Staff A said that Resident 1's Collateral Contact (CC) reported to them Resident 1 had bruising on their left hand of unknown origin, right before Thanksgiving Day (meaning 11/23/2023).

In an interview on 12/06/2023 at 3:45 PM, Resident 1 said that a week ago (meaning the week of November 27, 2023) they fell at night and hit their left hip on a walker. Resident 1 said that they reported to Staff B their fall incident the following day while Staff B was providing care to them and saw their left hip bruise.

On 12/06/2023 at 3:30 PM interview, Staff B said that they observed Resident 1 with a bruise on their left hip, one to two weeks ago and reported it to Staff A to document. Staff B said that they did not write any notes about what Resident 1 reported to them because they expected Staff A to write the report.

Record review of the home's incident log showed a blank form. There was no other record found in the home that track Resident 1's falls and subsequent skin trauma. There was no record found that Staff A recorded what Resident 1, their CC, and Staff B reported to them.

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) _____ Date 1-10-24

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

Findings included...

On 12/06/2023 at 3:10 PM, observation showed three residents and one Household Member (HM) being cared for in the AFH by Staff B, Caregiver. Staff A, Entity Representative arrived at the home at 3:15 PM.

In an interview on 12/06/2023 at 3:15 PM, Staff A said that there was no incident that happened in the home within the last three months. Staff A said that Resident 1's Collateral Contact (CC) reported to them Resident 1 had bruising on their left hand of unknown origin, right before Thanksgiving Day (meaning 11/23/2023).

In an interview on 12/06/2023 at 3:45 PM, Resident 1 said that a week ago (meaning the week of November 27, 2023) they fell at night and hit their left hip on a walker. Resident 1 said that they reported to Staff B their fall incident the following day while Staff B was providing care to them and saw their left hip bruise.

On 12/06/2023 at 3:30 PM interview, Staff B said that they observed Resident 1 with a bruise on their left hip, one to two weeks ago and reported it to Staff A to document. Staff B said that they did not write any notes about what Resident 1 reported to them because they expected Staff A to write the report.

Record review of the home's incident log showed a blank form. There was no other record found in the home that track Resident 1's falls and subsequent skin trauma. There was no record found that Staff A recorded what Resident 1, their CC, and Staff B reported to them.

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) Date

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

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) of 1 of 1 resident (Resident 1) addressed the mobility, transfer, and safety according to the resident's assessment. This failure place Resident 1 at risk for unmet care needs.

Findings included....

On 12/06/2023 at 3:33 PM, observation showed Resident 1 lying in bed, awake, and alert. A commode was observed six inches away from the edge and at the right side toward the foot of the bed. A walker was observed six inches away behind the commode. The walker was not within easy reach of Resident 1. A calling device was not observed anywhere in the bedroom.

On 12/06/2023 at 3:35 PM, the department staff with Staff A's, Entity Representative, observed Resident 1 with a left hip three point five inches in diameter skin area that was hard to touch. This skin was pale red violet in color. Around this skin area was dark purple, brown, and had yellow edges that measured eight point five inches long and six point five inches wide. Below this skin area to the left close to the buttock fold was another skin discoloration of purple to brown and had yellow edges.

In an interview on 12/06/2023 at 3:35 PM, Staff A said that they had not seen the skin discoloration and hard skin on Resident 1's left hip prior to 12/06/2023. Staff A said that Staff B did not report to them that Resident 1 had skin issue and was not aware Resident 1 had a fall.

In an interview on 12/06/2023 at 3:45 PM, Resident 1 said that they did not know where their calling device was and that they used the commode at night on their own. At this same time, Resident 1 demonstrated getting up from the bed to use the commode. The resident was able to sit at the edge of the bed. Resident 1 said, "I don't feel well right now. I feel lightheaded". Resident 1 said that a week ago (meaning the week of November 27, 2023) they fell at night and hit their left hip on a walker that was on the floor. Resident 1 said that they reported to Staff B their fall incident the following day while Staff B saw their left hip bruise.

Review of Resident 1's assessment dated 11/08/2023, safety section showed the resident, "Has fainting spells, gets dizzy every time they stand up, had broken their hips twice from falling and always needs someone present when getting up". This section showed a caregiver was always present when Resident 1 was getting up. The locomotion in room and immediate living environment section showed Resident 1 required extensive assistance with one person assistance. This section showed the caregivers had to keep assistive device (walker) within reach, and when using the walker, the caregivers had to direct the

walker and keep caregiver's hands on the resident. In the transfer section, Resident 1 required extensive assistance, physical assist with completing transfers, and monitor resident while the resident transfers. Also, the caregivers need to assist Resident 1 with a boost to stand up and guide to sit down. The toilet use section showed Resident 1 required extensive assistance with one-person physical assist. The skin care section showed the caregivers to complete weekly skin checks during showers and as needed.

Review of Resident 1's December 2023 medication administration record and the 11/08/2023 assessment, showed Resident 1 was taking a blood thinner (a medication to reduce risk of heart attacks and help keep blood clots from forming). The Mayo Clinic website on 12/22/2023 showed blood thinners have side effects of easy skin bruising and should be monitored in elderly population.

Record review of Resident 1's NCP dated 03/01/2023 showed on page five, "Caregivers gives Resident a call button within reach". The NCP did not show how often these interventions were supposed to be done. Also, on page five of the NCP, mobility section, showed Resident 1 "to use walker when getting around". The risk for fall section of the NCP showed Resident 1 was at risk for falls. The intervention showed, "Caregiver checks on Resident four times at night". This section did not show other fall prevention during the daytime hours and there was no documentation found the caregivers were rounding on the resident. Page six of the NCP, toileting section, showed Resident 1 used bedside commode. This task did not specify who, when, and how often this task was supposed to be done. This task did not follow the resident's assessment. Page seven of Resident 1's NCP, skin problem section, a "NO" box was checked. The NCP did not show the resident was taking a blood thinner, or the resident needed close monitoring of the skin.

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) 1-10-24 Date

walker and keep caregiver's hands on the resident. In the transfer section, Resident 1 required extensive assistance, physical assist with completing transfers, and monitor resident while the resident transfers. Also, the caregivers need to assist Resident 1 with a boost to stand up and guide to sit down. The toilet use section showed Resident 1 required extensive assistance with one-person physical assist. The skin care section showed the caregivers to complete weekly skin checks during showers and as needed.

Review of Resident 1's December 2023 medication administration record and the 11/08/2023 assessment, showed Resident 1 was taking a blood thinner (a medication to reduce risk of heart attacks and help keep blood clots from forming). The Mayo Clinic website on 12/22/2023 showed blood thinners have side effects of easy skin bruising and should be monitored in elderly population.

Record review of Resident 1's NCP dated 03/01/2023 showed on page five, "Caregivers gives Resident a call button within reach". The NCP did not show how often these interventions were supposed to be done. Also, on page five of the NCP, mobility section, showed Resident 1 "to use walker when getting around". The risk for fall section of the NCP showed Resident 1 was at risk for falls. The intervention showed, "Caregiver checks on Resident four times at night". This section did not show other fall prevention during the daytime hours and there was no documentation found the caregivers were rounding on the resident. Page six of the NCP, toileting section, showed Resident 1 used bedside commode. This task did not specify who, when, and how often this task was supposed to be done. This task did not follow the resident's assessment. Page seven of Resident 1's NCP, skin problem section, a "NO" box was checked. The NCP did not show the resident was taking a blood thinner, or the resident needed close monitoring of the skin.

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Provider (or Representative) _____ Date _____