STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

JoyTera Care Homes at Alicia Park LLC
JoyTera Care Homes at Alicia Park
3621 NE 100TH ST
SEATTLE, WA 98125

RE: JoyTera Care Homes at Alicia Park License # 753690

Dear Provider:

This letter addresses Compliance Determination(s) 54667 (Completion Date 02/11/2025) and 51214 (Completion Date 12/17/2024).

The Department completed a follow-up inspection of your Adult Family Home on 02/11/2025 and found that you have corrected the violations listed in the Complaint report dated 12/17/2024. Your home is back in compliance as of 01/31/2025 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 388-76-10830-2, WAC 388-76-10830-1

The Department staff who did the off-site verification:
Alina Zaharie, NCI

If you have any questions, please contact me at (253)341-7376.

Sincerely,

Alfredo Brown

Alfredo Brown, Allied Health Field Manager
Region 2, Unit K
Residential Care Services

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Statement of Deficiencies	License #: 753690	Compliance Determination #51214
Plan of Correction	JoyTera Care Homes at Alicia Park	Completion Date
Page 1 of 5	Licensee: JoyTera Care Homes at Alicia Park LLC	12/17/2024

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 12/04/2024 and 12/04/2024 of:

JoyTera Care Homes at Alicia Park
3621 NE 100TH ST
SEATTLE, WA 98125

This document references the following complaint number(s): 157302

The following sample was selected for review during the unannounced on-site visit: 2 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Alina Zaharie, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit K
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Renee' Bourque
Residential Care Services

12/31/2024
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.

Statement of Deficiencies	License #: 753690	Compliance Determination #51214
Plan of Correction	JoyTera Care Homes at Alicia Park	Completion Date
Page 2 of 5	Licensee: JoyTera Care Homes at Alicia Park LLC	12/17/2024

JOYCE MALLORI
Provider (or Representative)

2/2/2025
Date

WAC 388-76-10830 Emergency and disaster plan Required. The adult family home must have a written emergency and disaster plan to meet the needs of each resident during emergencies and disasters. The plan must include:

(1) Responding to natural and man-made emergencies and disasters that may reasonably occur at the home;

(2) Actions to be taken by staff and residents during and after an emergency or disaster; and

This requirement was not met as evidenced by:

Corrected on 2/2/25.

Based on observation, interview and record review, the Adult Family Home (AFH) failed to have a disaster plan that met the resident's need for being on an alternating pressure mattress (a therapeutic bed designed to prevent pressure sores and ulcers) and preventing pressure against a resident's skin when AFH remained without electrical power during a storm on 11/19/2024. This placed 1 of 5 residents (Resident 1) at risk for further skin damage and unmet care needs.

Findings included...

Note: A National Weather Service (NWS) Seattle Weather Briefing on 11/19/2024 at 11:02 AM, stated that on 11/19/2024 the King and Snohomish Lowlands (including Marysville, Everett, Seattle, Bellevue) were at risk of wind and rain showers for 11/19/2024-Tuesday and 11/20/2024-Wednesday. The NSW stated that the peak winds were forecast from Tuesday afternoon through early Wednesday morning, between 5:00 PM Tuesday through 3:00 AM Wednesday. The NSW stated damaging, gusty winds may cause widespread power outages and road closures due to downed trees and powerlines.

Observation on 12/04/2024 at 1:00 PM, showed Resident 1 had two pressure ulcers (areas of damaged skin or tissue that can occur when skin is under pressure for a long time) on their buttock's region. Observation showed Staff B, Resident manager changed Resident 1's wound dressing from their right hip bone. Observation showed that the dressing presented with a moderate pink yellowish drainage on the abdominal pad (gauze that is used to absorb drainage from heavily draining wounds). Observation showed 2 pieces of gauze to be approximately 2 x2 cm packed inside resident wound. Observation showed Staff B removed the gauze. Observation showed the wound measured approximately 6 cm in length and 5 cm width. Observation showed the wound to be deep inside resident muscle having slough skin (a type of non-viable fibrous yellow-greenish skin that forms because of infection or damage tissue). Observation showed redness area around the wound. Observation showed Resident 1

Provider (or Representative) _____ Date _____

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had a second pressure ulcer on their sacrum region (lower back) that measured 5 cm length and 5 cm in width with irregular margins of the wound. Observation showed the wound surface being covered in a slough skin (a type of non-viable fibrous yellow-greenish skin that forms because of infection or damage tissue). Observation showed open skin surrounding the wound with no bleeding.

Review of AFH records showed Resident 1 admitted to the AFH on [redacted]/2024 with multiple diagnoses, including [redacted].

Review of Resident 1's Progress Note dated [redacted]/2024 showed Resident 1 had admitted with an existing wound on their right ischium (right lower hip bone).

Review of AFH Progress Note dated 11/20/2024 showed Resident 1 had developed a new pressure sore on their coccyx area (most inferior bone in the spinal column).

Review of Resident 1's wound order, dated 10/16/2024, indicated that some of the barriers to pressure healing include mechanical forces of pressure (the force exerted by a fluid or a solid object due to its pressure), friction and shear (when forces applied to the body tissues or parts of the cause these tissues to move in opposite directions). Review of Resident 1 wound order indicated that the plan was to eliminate or control underlying cause and barriers to healing. Review of the wound order included some short-term goals that promoted wound healing: redistribute pressure, prevent further trauma, absorb exudate (fluid released by an organism through pores or a wound), decrease odor, etc. Resident 1's wound order plan indicated the need for pressure redistribution by establishing a turning/reposition schedule at least every 2 hours and limited the head of the bed elevation to 30 degrees. Another order indicated low air loss bed (a specialized type of medical mattress designed to: prevent and treat pressure ulcers or bed sores, reduce pressure on the skin, promote airflow to the patient's body by utilize a system of air-filled chambers or cells).

Review of Resident 1's Assessment, dated 11/01/2024, indicated under the skin section that Resident 1 had risk for skin breakdown and that had a pressure ulcer stage 4 (a skin injury with a deep tissue destruction extending to muscle, bone and tendons) on their Ischium (right lower hip bone). Assessment showed Resident 1 needed to be reposition in bed every 2 hours during awake time and at every 3-4 hours at nighttime. Assessment showed Resident 1 had been on a pressure alternating mattress. Resident 1's Assessment showed under the mobility section that Resident 1 was dependent and that requires 2 persons assistance with reposition.

Review of Resident 1's Negotiated Care Plan (NCP), dated 01/01/2024, indicated under sleep section that caregivers will turn Resident 1 at every 2-4 hours.

Review of an undated AFH Disaster Plan showed that AFH's had written power outage plan did not contain specific instructions and staff actions regarding Resident 1's

alternating pressure mattress which relies on a constant need of an electrical source power. The AFH Disaster plan did not contain any information that addressed a back-up system or identified conditions in which the AFH would notify emergency services during a power outage when the Resident 1's care needs could not be met at the AFH.

During an interview on 12/03/2024 at 12:25 PM, CC1 (Collateral Contact 1), stated that they visited Resident 1 on 11/20/2024 around 12:30 PM. The CC1 stated that they found Resident 1 lying on a completely uninflated air mattress with their head of bed elevated at 50 degree and legs at 20 degrees. The CC1 stated that Resident 1 told them that they had been on that position since the home lost power on 11/19/2024 at 6:30 PM. The CC1 stated that they had to figure out how to level Resident 1's bed. The CC1 stated that AFH staff did not know how to level Resident 1's bed. The CC1 stated that Resident 1 developed a new pressure ulcer on their sacrum (lower back) area.

During an interview on 12/04/2024 at 11:33 AM, Resident 1 stated that their mattress slowly deflated on 11/19/2024 at dinner time after AFH lost electrical power. Resident 1 stated that AFH staff had not done anything to immediately address the deflated air mattress until noon of the following day (11/20/2024). Resident 1 stated that around noon on 11/20/2024 AFH staff changed their deflated air mattress with a regular mattress. Resident 1 stated that the AFH staff had changed their deflated mattress after home health nurses figured the type of batteries and where to put the batteries for their bed to be leveled. Resident 1 stated that they slept all night on their back in an uncomfortable position on a completely deflated mattress. Resident 1 stated that they are not able to feel their lower part of the body. Resident 1 stated that the AFH staff repositioned them 2 or 3 times per day. Resident 1 stated that AFH staff had not repositioned them during nighttime when the power went out. Resident 1 stated that sometimes they refused to let AFH staff reposition them due to their discomfort. Resident 1 stated that they are aware of the need to change positions to prevent further skin breakdown. Resident 1 stated that they were placed on the air mattress back after power came back on 11/21/2024, Thursday morning.

During an interview on 12/04/2024 at 11:55 AM, Staff B, stated that Resident 1 had developed a new pressure injury two weeks ago due to Resident 1 being bed bound and refusing to be repositioned in the afternoon. Staff B stated that the AFH had no generator or back-up source of power. Staff B stated that they did not know how to level the bed during power outage. Staff B stated that it was not until home health nurses helped them, that they figured out that Resident 1's bed can function with 2 batteries of 9 Voltage (unit of electrical charge). Staff B stated that the new pressure injury that Resident 1 had developed may have been caused due to Resident 1 sleeping on the deflated mattress during the power outage. Staff B stated that they noticed the Resident 1 mattress being completely deflated on 11/20/2024 during morning care. Staff B stated that they called Staff A, Provider, who advise them to place a regular mattress under Resident 1. Staff B stated that they do not get power outage often and that they had no idea how to level Resident 1's bed.

During an interview on 12/04/2024 at 12:27 PM, Staff D, Caregiver stated that the moment the power went out on 11/19/2024 they brought flashlights and passed out blankets to all residents. Staff D stated that they went home when their shift ended at

7:00 PM. Staff D stated that on 11/20/2024 at 7:50 AM they noticed Resident 1's air mattress was deflated and Resident 1's head of bed was up at 50-degree angle. Staff D stated that they tried to changed Resident 1 deflated mattress in the morning with a regular mattress but Resident 1 had refused. Staff D stated that Resident had told them that was too cold in the room. Staff D stated that they changed Resident 1's mattress at noon with the help of Resident 1's home health nurses. Staff D stated that they did not know how to put the head of the bed down and level the bed without having electrical power. Staff D stated that the power had been restored back at the AFH after 36 hours.

During an interview on 12/04/2024 at 1:50 PM, Staff A, Provider stated that they missed the opportunity to immediately address the Resident 1's deflated mattress during the power outage. Staff A stated that they were overwhelmed, and the power outage affected several of their AFHs. Staff A stated that after power went out, they made sure that the AFH residents had extra blankets and flashlights. Staff A stated that they did not check on Resident 1 before they went home and that they missed the chance to have an immediate plan to address Resident 1's mattress. Staff A stated that they were aware a deflated mattress may worsen Resident 1's pressure ulcer or lead to new pressure ulcer. Staff A stated that Resident 1 had a pressure ulcer before on their sacrum region that had been healed but now it had reopened. Staff A stated that they thought power would be restored in a couple of hours. Staff A stated that they came with a plan to change Resident 1 mattress the morning after the storm. Staff A stated that they did not know how to run Resident 1's bed with back-up batteries. Staff A stated that they do not know if Resident 1's air mattress machine could be operated with batteries. Staff A stated that they would need to read the air mattress machine's manual. Staff A stated that it had not occurred to them to call 911 to have the Resident 1 transferred to the hospital. Staff A stated that they were not prepared for a 36-hour power outage. Staff A stated that they will take the responsibility of their actions or inactions and that they will work on developing a better disaster plan going further.

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, JoyTera Care Homes at Alicia Park is or will be in compliance with this law and / or regulation on (Date) 2/2/2025.

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

JOYCE MALORI — Provider (or Representative)

2/2/2025 — Date

7:00 PM. Staff D stated that on 11/20/2024 at 7:50 AM they noticed Resident 1's air mattress was deflated and Resident 1's head of bed was up at 50-degree angle. Staff D stated that they tried to changed Resident 1 deflated mattress in the morning with a regular mattress but Resident 1 had refused. Staff D stated that Resident had told them that was too cold in the room. Staff D stated that they changed Resident 1's mattress at noon with the help of Resident 1's home health nurses. Staff D stated that they did not know how to put the head of the bed down and level the bed without having electrical power. Staff D stated that the power had been restored back at the AFH after 36 hours.

During an interview on 12/04/2024 at 1:50 PM, Staff A, Provider stated that they missed the opportunity to immediately address the Resident 1's deflated mattress during the power outage. Staff A stated that they were overwhelmed, and the power outage affected several of their AFHs. Staff A stated that after power went out, they made sure that the AFH residents had extra blankets and flashlights. Staff A stated that they did not check on Resident 1 before they went home and that they missed the chance to have an immediate plan to address Resident 1's mattress. Staff A stated that they were aware a deflated mattress may worsen Resident 1's pressure ulcer or lead to new pressure ulcer. Staff A stated that Resident 1 had a pressure ulcer before on their sacrum region that had been healed but now it had reopened. Staff A stated that they thought power would be restored in a couple of hours. Staff A stated that they came with a plan to change Resident 1 mattress the morning after the storm. Staff A stated that they did not know how to run Resident 1's bed with back-up batteries. Staff A stated that they do not know if Resident 1's air mattress machine could be operated with batteries. Staff A stated that they would need to read the air mattress machine's manual. Staff A stated that it had not occurred to them to call 911 to have the Resident 1 transferred to the hospital. Staff A stated that they were not prepared for a 36-hour power outage. Staff A stated that they will take the responsibility of their actions or inactions and that they will work on developing a better disaster plan going further.

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