STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

6/5/2024

AFH at Silver Lake, LLC

AFH at Silver Lake LLC
18305 15th place W
Lynnwood, WA 98037

RE: AFH at Silver Lake LLC License # 753755

Dear Provider:

This letter addresses Compliance Determination(s) 41876 (Completion Date 05/29/2024) and 33780 (Completion Date 03/18/2024).

The Department completed a follow-up inspection of your Adult Family Home on 05/29/2024 and found that you have corrected the violations listed in the Complaint report dated 03/18/2024. Your home is back in compliance as of 04/18/2024 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 388-76-10490-1, WAC 388-76-10400-3-b, WAC 388-76-10673-1-a, WAC 388-76-10673-2, WAC 388-76-10673-2-a, WAC 388-76-10673-2-b

The Department staff who did the on-site verification:
Patricia Young, Community Complaint Investigator

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn

Nicholette Flynn, Field Manager
Region 2, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: AFH at Silver Lake LLC
Provider Type: Adult Family Home
License/Cert.#: 753755
Compliance Determination #: 33780
Intake ID: 108472
Investigator: Patricia Young
Region/Unit #: RCS Region 2 / Unit B
Investigation Date(s): 12/12/2023 through 03/18/2024
Complainant Contact Date(s):

Allegation(s):

1. An unnamed caregiver yelled at an unnamed resident.
2. An unnamed resident had a bruise on their forehead.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	Exterior/Interior environments Residents Resident rooms Staff to resident interactions
Interviews:	Identified staff Residents Family members Caregiver Provider
Record Reviews:	Facility records Resident records

Investigation Summary:

1. One sampled caregiver stated that they heard another caregiver yell at a named resident usually daily. The caregiver stated they had to be stern with the residents if they had to repeat themselves. Failed practice cited.
2. One sampled resident was noted to have bruises on their hand and eye of unknown origin. Four sampled residents did not have any visible bruising to their faces. Failed practice cited.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: AFH at Silver Lake LLC
Provider Type: Adult Family Home
License/Cert.#: 753755
Compliance Determination #: 33780
Intake ID: 110060
Investigator: Patricia Young
Region/Unit #: RCS Region 2 / Unit B
Investigation Date(s): 12/12/2023 through 03/18/2024
Complainant Contact Date(s):

Allegation(s):

1. A named caregiver pulled a named resident up out of a chair by her hair.
2. A named caregiver yelled at a named resident.
3. A named resident had bruises of unknown origin.
4. A named caregiver was left alone with the residents without proper credentials.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	Exterior/Interior environments Residents Resident rooms Staff to resident interactions
Interviews:	Identified staff Residents Family members Caregiver Provider
Record Reviews:	Facility records Resident records

Investigation Summary:

1. One sampled caregiver stated that they witnessed the named caregiver pull the named resident out of the chair by their hair. The named resident was not able to be interviewed due to cognitive deficits. The named caregiver stated they did not physically abuse or harm the residents. Failed practice cited.
2. One sampled caregiver stated that they heard the named caregiver yell at the named resident usually daily when they were not cooperating with care. The named caregiver stated they had to be stern with the residents if they had to repeat themselves during care. Failed practice cited.
3. The named resident was observed to have two bruises of unknown origin. The named resident's representative stated they saw the bruises. The Adult Family Home (AFH) representative (AFHR) and one sampled caregiver stated they were not made

aware of the bruises. One sampled caregiver stated they told the AFHR about the bruises and that another caregiver was caring for the named resident just before they appeared. Failed practice cited.
4. The AFHR and the named caregiver stated they were not left alone in the AFH. The AFHR and the named caregiver stated that they gave medications and care with supervision.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: AFH at Silver Lake LLC
Provider Type: Adult Family Home
License/Cert.#: 753755
Compliance Determination #: 33780
Intake ID: 119627
Investigator: Patricia Young
Region/Unit #: RCS Region 2 / Unit B
Investigation Date(s): 12/12/2023 through 03/18/2024
Complainant Contact Date(s): 02/20/2024, 02/21/2024, 03/22/2024

Allegation(s):

1. The Adult Family Home (AFH) caregivers gave the residents extra medications for agitation without physicians' orders.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Caregivers' room
Interviews:	Residents Family members Other agency's medical staff Caregivers Provider
Record Reviews:	Facility records Resident records Medication administration records Employee records

Investigation Summary:

1. One sampled caregiver stated they gave a resident a dose of an antipsychotic medication that they were not ordered, that was ordered for another resident, and that was expired because the Adult Family Home (AFH) representative (AFHR) told them to. Two bingo cards with expired antipsychotic and anti-anxiety medications for two residents of the AFH were observed stored in the open and unlocked in the staffs' room in the AFH. The AFHR stated they did not know the expired medications were in the staffs' room. The AFHR stated they did not tell the staff to administer medications that were not ordered to the residents. One sampled resident stated they did not think they got wrong medication. Failed practice cited.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: AFH at Silver Lake LLC
Provider Type: Adult Family Home
License/Cert.#: 753755
Compliance Determination #: 33780
Intake ID: 120003
Investigator: Patricia Young
Region/Unit #: RCS Region 2 / Unit B
Investigation Date(s): 12/12/2023 through 03/18/2024
Complainant Contact Date(s):

Allegation(s):

1. The named caregiver kept residents' expired medications in the caregivers' room.
2. A named resident was sexually inappropriate with the named caregiver.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Caregivers' room
Interviews:	Residents Family members Other agency's medical staff Caregivers Provider
Record Reviews:	Facility records Resident records Medication administration records Employee records

Investigation Summary:

1. One sampled caregiver stated they gave a resident a dose of an antipsychotic medication that they were not ordered, that was ordered for another resident, and that was expired because the Adult Family Home (AFH) representative (AFHR) told them to. Two bingo cards with expired antipsychotic and anti-anxiety medications for two residents of the AFH were observed stored in the open and unlocked in the staffs' room in the AFH. The AFHR stated they did not know the expired medications were in the staffs' room. The AFHR stated they did not tell the staff to administer medications that were not ordered to the residents. One sampled resident stated they did not think they got wrong medication. Failed practice cited.
2. The named resident stated that the named caregiver did not make them feel uncomfortable and they felt safe at the AFH. One sampled caregiver stated they

witnessed what they felt were inappropriate interactions between the named caregiver and the named resident, which they reported to the AFHR. The AFHR stated they investigated the allegations and did not believe the named caregiver was inappropriate with the named resident. Interview and record review showed the named resident's primary care provider and representative were notified of the allegations.

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
3906-172nd St NE, Suite #100, Arlington, WA 98223

Statement of Deficiencies	License #: 753755	Compliance Determination # 33780
Plan of Correction	AFH at Silver Lake LLC	Completion Date
Page 1 of 8	Licensee: AFH at Silver Lake, LLC	03/18/2024

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 12/12/2023 and 02/21/2024 of:

AFH at Silver Lake LLC
11724 23rd Dr SE
Everett, WA 98208

This document references the following complaint number(s): 108472, 110060, 119627, 120003

The following sample was selected for review during the unannounced on-site visit: 5 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Patricia Young, Community Complaint Investigator
Nicholette Flynn, AFH Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

As a result of the on-site visit(s), the department found that you are not in compliance w 1 the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

nflynn
Residential Care Services

03/27/2024
Date

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 12/12/2023 and 02/21/2024 of:

AFH at Silver Lake LLC
11724 23rd Dr SE
Everett, WA 98208

This document references the following complaint number(s): 108472, 110060, 119627, 120003

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From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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 _____ 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.

M.Li Vm
Provider (or Representative)

4/7/2024
Date

IDR
4-8-2024

WAC 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

(1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the Adult Family Home (AFH) failed to ensure that 2 of 5 residents' (Residents 2 & 5) expired medications were disposed of per AFH policy. This failure placed residents in the home at risk for being given discontinued or expired medications and medications being used improperly.

Findings included...

Record review of the AFH's undated medication disposal policy titled, "AFH at Silver Lake, LLC Medication Disposal Policy", showed that expired medications were to be placed in a drug buster (a device that destroys medications) until the medications are 1 inch from the bottle opening, then discard in the regular trash.

Record review showed that the AFH admitted Resident 2 on [redacted]2022 with multiple health diagnoses. Review of Resident 2's assessment, dated 03/01/2023, showed Resident 2 required caregiver assistance with medications.

Record review showed that the AFH admitted Resident 5 on [redacted]2022 with multiple health diagnoses. Review of Resident 5's assessment, dated 11/28/2023, showed Resident 5 required caregiver assistance with medications.

Observation on 02/21/2024 at 12:08 PM, showed the following pharmacy packaged resident medication cards were observed on the bedside table in the caregivers' room:

- Resident 2's Seroquel 25 mg tablets, a medication used to correct the imbalance of chemicals in the brain and ease the symptoms of certain mental health conditions, showed an expiration date of 04/05/2023. Twenty-seven out of thirty tablets remained in the medication card.

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 388-76-10490 Medication disposal Written policy Required. The adult family home must have and implement a written policy addressing the disposal of unused or expired resident medications. Unused and expired medication must be disposed of in a safe manner for:

(1) Current residents living in the adult family home; and

This requirement was not met as evidenced by:

Based on interview, observation, and record review, the Adult Family Home (AFH) failed to ensure that 2 of 5 residents' (Residents 2 & 5) expired medications were disposed of per AFH policy. This failure placed residents in the home at risk for being given discontinued or expired medications and medications being used improperly.

Findings included…

Record review of the AFH's undated medication disposal policy titled, "AFH at Silver Lake, LLC Medication Disposal Policy", showed that expired medications were to be placed in a drug buster (a device that destroys medications) until the medications are 1 inch from the bottle opening, then discard in the regular trash.

Record review showed that the AFH admitted Resident 2 on [redacted]/2022 with multiple health diagnoses. Review of Resident 2's assessment, dated 03/01/2023, showed Resident 2 required caregiver assistance with medications.

Record review showed that the AFH admitted Resident 5 on [redacted]/2022 with multiple health diagnoses. Review of Resident 5's assessment, dated 11/28/2023, showed Resident 5 required caregiver assistance with medications.

Observation on 02/21/2024 at 12:08 PM, showed the following pharmacy packaged resident medication cards were observed on the bedside table in the caregivers' room:

- Resident 2's Seroquel 25 mg tablets, a medication used to correct the imbalance of chemicals in the brain and ease the symptoms of certain mental health conditions, showed an expiration date of 04/05/2023. Twenty-seven out of thirty tablets remained in the medication card.

- Resident 5's Ativan 0.5 mg, a medication used for the management of anxiety disorders, sleeplessness, panic attacks, and alcohol withdrawal, showed an expiration date of 02/18/2023. Seven out of ten tablets remained in the medication card.

During an interview on 02/21/2024 at 12:08 PM, Staff B (Caregiver) stated that expired Seroquel and Ativan were kept in the caregivers' room on a table. Staff B stated that the expired medications belonged to Resident 2 and Resident 5. Staff B stated that Staff A (Entity Representative) told the caregivers to give all the residents a dose of the expired Seroquel or Ativan that belonged to Residents 2 and 5 if they were agitated whether that medication was ordered for them or not.

During an interview on 02/21/2024 at 12:22 PM, Staff F (Caregiver) stated that they did not know there were expired medications in the caregivers' room. Staff F stated Staff A never told them to give residents medications that they were not ordered.

During an interview on 02/21/2024 at 12:44 PM, Staff A stated that they were not aware that there were expired medications in the caregivers' room. Staff A stated that they never told caregivers to give the expired medications to residents for agitation without an order.

During an interview on 02/27/2024 at 03:15 PM, Staff E (Caregiver) stated that they did not know there were expired medications in the caregivers' room. Staff E stated that Staff A never told them to give the expired medications to residents for agitation. IDR 4/8/24

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date) 4/18/24 .

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

Miki Um, RN — Provider (or Representative)

4/18/24 — Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives: IDR 4/8/24

(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:

• Resident 5's Ativan 0.5 mg, a medication used for the management of anxiety disorders, sleeplessness, panic attacks, and alcohol withdrawal, showed an expiration date of 02/18/2023. Seven out of ten tablets remained in the medication card.

During an interview on 02/21/2024 at 12:08 PM, Staff B (Caregiver) stated that expired Seroquel and Ativan were kept in the caregivers' room on a table. Staff B stated that the expired medications belonged to Resident 2 and Resident 5. Staff B stated that Staff A (Entity Representative) told the caregivers to give all the residents a dose of the expired Seroquel or Ativan that belonged to Residents 2 and 5 if they were agitated whether that medication was ordered for them or not.

During an interview on 02/21/2024 at 12:22 PM, Staff F (Caregiver) stated that they did not know there were expired medications in the caregivers' room. Staff F stated Staff A never told them to give residents medications that they were not ordered.

During an interview on 02/21/2024 at 12:44 PM, Staff A stated that they were not aware that there were expired medications in the caregivers' room. Staff A stated that they never told caregivers to give the expired medications to residents for agitation without an order.

During an interview on 02/27/2024 at 03:15 PM, Staff E (Caregiver) stated that they did not know there were expired medications in the caregivers' room. Staff E stated that Staff A never told them to give the expired medications to residents for agitation.

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

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:

Statement of Deficiencies	License #: 753755	Compliance Determination # 33780
Plan of Correction	AFH at Silver Lake LLC	Completion Date
Page 4 of 8	Licensee: AFH at Silver Lake, LLC	03/18/2024

Based on interview, observation, and record review, the Adult Family Home (AFH) failed to ensure 1 of 5 Residents (Resident 3) was cared for in a safe manner when a caregiver administered a medication that was expired and not ordered for Resident 3. This failure placed Resident 3 at risk for an adverse medication reaction and physical harm.

Findings included...

Record review showed Resident 3 was admitted to the AFH on [redacted] 2024 with multiple health diagnoses that included [redacted]

During an interview on 02/21/2024 at 12:08 PM, Staff B (Caregiver) stated that the expired Seroquel (a medication used to correct the imbalance of chemicals in the brain and ease the symptoms of certain mental health conditions) was kept in the caregivers' room on a table. Staff B stated that the expired medication belonged to Resident 2. Staff B stated that Staff A (Entity Representative) told the caregivers to give all the residents a dose of the expired Seroquel that belonged to Resident 2 if they were agitated whether that medication was ordered for them or not. Staff B stated that they gave Resident 3 one expired Seroquel 25 mg on 02/20/2024 at 07:00 PM because Staff A told them to give Resident 3 the medication for agitation.

Observation on 02/21/2024 at 12:08 PM, Resident 2's Seroquel 25mg pharmacy packaged medication card was observed on the bedside table in the caregivers' room. Twenty-seven out of thirty tablets remained in the medication card.

Record review on 02/21/2024 at 12:28 PM of Resident 3's medication records, showed that Resident 3 was not ordered to take Seroquel.

During an interview on 02/21/2024 at 12:44 PM, Staff A stated that they never told Staff B to give Resident 3 a dose of expired Seroquel 25 mg for agitation.

IDR 4/18/24

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date) 4/18/24.

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

Miki Um, RN — Provider (or Representative)

4/18/24 — Date

Based on interview, observation, and record review, the Adult Family Home (AFH) failed to ensure 1 of 5 Residents (Resident 3) was cared for in a safe manner when a caregiver administered a medication that was expired and not ordered for Resident 3. This failure placed Resident 3 at risk for an adverse medication reaction and physical harm.

Findings included…

Record review showed Resident 3 was admitted to the AFH on [redacted]/2024 with multiple health diagnoses that included [redacted].

During an interview on 02/21/2024 at 12:08 PM, Staff B (Caregiver) stated that the expired Seroquel (a medication used to correct the imbalance of chemicals in the brain and ease the symptoms of certain mental health conditions) was kept in the caregivers' room on a table. Staff B stated that the expired medication belonged to Resident 2. Staff B stated that Staff A (Entity Representative) told the caregivers to give all the residents a dose of the expired Seroquel that belonged to Resident 2 if they were agitated whether that medication was ordered for them or not. Staff B stated that they gave Resident 3 one expired Seroquel 25 mg on 02/20/2024 at 07:00 PM because Staff A told them to give Resident 3 the medication for agitation.

Observation on 02/21/2024 at 12:08 PM, Resident 2's Seroquel 25mg pharmacy packaged medication card was observed on the bedside table in the caregivers' room. Twenty-seven out of thirty tablets remained in the medication card.

Record review on 02/21/2024 at 12:28 PM of Resident 3's medication records, showed that Resident 3 was not ordered to take Seroquel.

During an interview on 02/21/2024 at 12:44 PM, Staff A stated that they never told Staff B to give Resident 3 a dose of expired Seroquel 25 mg for agitation.

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Provider (or Representative) Date

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 interview, observation, and record review, the Adult Family Home (AFH) failed to ensure the allegations of abuse for 2 of 5 residents (Residents 1 & 2) were reported to the Department and law enforcement. This failure resulted in the delayed investigation of the allegations of abuse and resulted in the risk of further abuse to AFH residents.

Findings included…

Per WAC 388-76-10000, "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. (1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. (2) Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:
"Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.
"Mental abuse" means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

Record review of the AFH's undated abuse policy titled "AFH at Silver Lake, LLC Policy Prohibiting Abuse, Neglect, and Exploitation, and Employee Reporting and Documentation Requirements", showed that the AFH did not allow any form of abuse and required staff to immediately report any allegation of abuse to the Department's toll-free telephone number. The policy showed that staff members were not to interfere with the requirement that employees and other mandated reporters file reports of abuse. The policy showed that any staff under investigation for abuse, abandonment, neglect, and exploitation of residents will not have access to any of the residents during the investigation. The policy stated that employees who did not follow the policy would be subject to corrective action, including termination of employment. The policy required staff to sign an

acknowledgement that indicated staff read the policy, were trained, and understood the directives.

Record review of the AFH's employee records, undated, showed that Staff B (Caregiver) began employment on 02/04/2022. The AFH's undated abuse policy titled "AFH at Silver Lake, LLC Policy Prohibiting Abuse, Neglect, and Exploitation, and Employee Reporting and Documentation Requirements" showed Staff B signed the policy on 02/04/2022.

Record review of the AFH's employee records, undated, showed that Staff C (Caregiver) began employment on 09/25/2023. The AFH's undated abuse policy titled "AFH at Silver Lake, LLC Policy Prohibiting Abuse, Neglect, and Exploitation, and Employee Reporting and Documentation Requirements" showed Staff C signed the policy on 09/29/2023.

Record review showed that the AFH admitted Resident 1 on [redacted]/2022 with multiple health diagnoses, including [redacted].

Record review showed that the AFH admitted Resident 2 on [redacted]/2022 with multiple health diagnoses, including [redacted].

During an interview on 12/12/2023 at 9:37 AM, Staff B stated that on 12/12/2023 at 7:37 AM they witnessed Staff C pull Resident 1 by their hair out of the chair in Resident 1's bedroom. Staff B stated that she did not hear Staff C or Resident 1 say anything during that incident. Staff B stated that they have heard Staff C disrespectfully yell at Resident 1 when Resident 1 was not cooperating with care usually daily. Staff B stated that on 12/11/2023, they noticed another resident, Resident 2, had bruises on their face and hand. She stated that Staff C had been caring for Resident 2 just prior to the bruises being noticed on 12/11/2023. Staff B stated that they reported Resident 2's hair being pulled and Resident's 2 bruises to Staff A (Entity Representative) on 12/12/2023 after Resident 2's hair pulling incident occurred, but they could not remember what time. Staff B stated that Staff A stated they were going to talk to Staff C to prevent future incidents.

During an interview on 12/12/2023 at 9:55 AM, Staff A stated that they were not made aware of the alleged abuse of Resident 1 or the bruises on Resident 2.

During an interview on 12/12/2023 at 10:30 AM, Staff C stated that they never abused or physically harmed the residents. Staff C stated that they had to be stern with the residents if they had to repeat themselves. Staff C stated that they did not know that Resident 2 had bruises.

During an observation and attempted interview on 12/12/2023 at 10:46 AM, Resident 1 was observed to be groomed, dressed, and clean without bruising to exposed skin. Resident 1 appeared calm and was seated in a chair in their room. They were unable to answer questions.

During an observation and attempted interview on 12/12/2023 at 11:30 AM, Resident 2 was observed to be groomed, dressed, and clean. Resident 2 was awake and calm, but unable to answer any questions. Resident 2 had an approximately 2-centimeter dark purple discoloration to the back of her left hand and an approximately 1-centimeter red discoloration to the crease of her right eye.

Record review of the Department's Secure Tracking and Reporting System (STARS) on 12/18/2023 at 11:03 AM showed that no reports were made to the Department about the incident that occurred on 12/12/2023 involving Resident 1 and Staff C or the bruising to Resident 2.

During an interview on 12/22/2023 at 08:59 AM, Staff A and Staff D (Co-provider) stated that Staff A was not at the AFH when the incidents occurred, and that Staff B was on duty with Staff C. Staff A stated that they were not told by Staff B that Staff C abused Resident 1. Staff D stated that Staff B reported that Staff C may have been brushing or putting a hair tie in Resident 1's hair and Staff B was not sure if they witnessed abuse. Staff D stated that Staff B made the allegations against Staff C because they were trying to get back at Staff C. Staff A stated that they did receive a text message from Staff B about the incident on 12/12/2023. Staff D stated that the bruises on Resident 2 were not due to abuse. Staff A stated that Staff C has not returned to work at the AFH since they were told to leave their shift on 12/12/2023.

During an interview on 01/16/2024 at 10:53 AM, Staff B stated that they were not being coerced into changing their story. Staff B stated that they knew what their eyes saw, and they saw Staff C pull Resident 1 up by their hair. Staff B stated that they attempted to call the Department Hotline to report the incident, and something was wrong because it didn't work. Staff B stated that they notified Staff A, by text message, that they tried to report to the hotline. Staff B stated that Staff A replied and asked Staff B what happened. Staff B stated that they explained the incident with Resident 1 but did not receive a reply because Staff A was on their way to the AFH.

During an interview on 02/21/2024 at 09:40 AM, Staff B stated that on 12/12/2024 they witnessed Staff C pull Resident 1 out of a chair by their hair in their bedroom. Staff B stated that they had the text messages that they sent to Staff A about the incident saved on their phone. Staff B stated they did not call the Department's Hotline or law enforcement.

Observation on 02/21/2024 at 12:08 PM of Staff B's cell phone, showed a text message conversation between Staff B and Staff A on 12/12/2023 7:40 AM. The phone number listed for Staff A's text messages was verified as the same number the Department has on file for Staff A's cell phone.

Record review of text messages, dated 12/12/2023 at 7:40 AM, showed that Staff B told Staff A that Staff C pulled Resident 1's hair. Staff B stated the incident was abuse and was

reportable. Staff A told Staff B in the text messages to ask Staff C about the incident. Staff A told Staff B to tell Staff C that the action Staff C did was considered a very serious resident abuse. Staff B stated that Staff C had a prior incident of pulling Resident 1's hair. The text messages showed Staff A told Staff B to delete all text messages and pictures, anything related to Staff C.

In an interview on 3/18/2024 at 2:56 PM, Staff A stated that Staff B texted Staff A's cell phone the morning of 12/12/2023 starting between 08:00 AM and 10:00 AM to tell her that Staff B witnessed Staff C pull Resident 1's hair. Staff A stated that they were coming to investigate the allegations. Staff A stated that they did not want to jump to conclusions and wanted to see what happened for themself. Staff A stated they did not tell Staff B to delete the text messages. Staff A stated they deleted the text messages. Staff A then stated that the phone broke and that was why the messages were lost.

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date) 4/18/24 .

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

Miki Um, RN
Provider (or Representative)

4/18/24
Date

IDR 4/22/24

reportable. Staff A told Staff B in the text messages to ask Staff C about the incident. Staff A told Staff B to tell Staff C that the action Staff C did was considered a very serious resident abuse. Staff B stated that Staff C had a prior incident of pulling Resident 1's hair. The text messages showed Staff A told Staff B to delete all text messages and pictures, anything related to Staff C.

In an interview on 3/18/2024 at 2:56 PM, Staff A stated that Staff B texted Staff A's cell phone the morning of 12/12/2023 starting between 08:00 AM and 10:00 AM to tell her that Staff B witnessed Staff C pull Resident 1's hair. Staff A stated that they were coming to investigate the allegations. Staff A stated that they did not want to jump to conclusions and wanted to see what happened for themself. Staff A stated they did not tell Staff B to delete the text messages. Staff A stated they deleted the text messages. Staff A then stated that the phone broke and that was why the messages were lost.

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, AFH at Silver Lake LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Provider (or Representative) Date