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

6/21/2023

Faithful Passion Care LLC

Faithful Passion Care LLC
7425 204th St SW
Lynnwood, WA 98036

RE: Faithful Passion Care LLC License # 754257

Dear Provider:

This letter addresses Compliance Determination(s) 25333 (Completion Date 06/14/2023) and 21570 (Completion Date 04/25/2023).

The Department completed a follow-up inspection of your Adult Family Home on 06/14/2023 and found that you have corrected the violations listed in the Complaint report dated 04/25/2023. Your home is back in compliance as of 06/09/2023 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 388-76-10400-1, WAC 388-76-10400-2, WAC 388-76-10400-3-c, WAC 388-76-10225-2, WAC 388-76-10225-2-a, WAC 388-76-10225-2-b, WAC 388-76-10225-2-c, WAC 388-76-10225-2-d, WAC 388-76-10225-2-f

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

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Nicholette Flynn

Renee Bourque, Field Manager
Region 2, Unit B
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Faithful Passion Care LLC **Provider Type:** Adult Family Home

License/Cert.#: 754257 **Intake ID:** 74477
Compliance Determination #: 21570 **Region/Unit #:** RCS Region 2 / Unit B
Investigator: Patricia Young
Investigation Date(s): 03/27/2023 through 04/25/2023
Complainant Contact Date(s): 03/24/2023, 03/27/2023, 03/29/2023, 04/06/2023

Allegation(s):

1. The adult family home (AFH) did not reposition or elevate the heels of the named resident every two hours.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions Food preparation Identified resident
Interviews:	Identified staff Residents Family members Social services staff Nursing staff
Record Reviews:	Resident records Facility records Medical records

Investigation Summary:

1. The AFH representative stated that they did not turn or reposition the named resident every two hours. The named resident stated they were not turned or repositioned every two hours. The named resident sustained pressure injuries. Failed practice cited.

Conclusion / Action:

☒ 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

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 03/27/2023 and 03/27/2023 of:

Faithful Passion Care LLC
1430 112TH ST SE
EVERETT, WA 98208

This document references the following complaint number(s): 74477

The following sample was selected for review during the unannounced on-site visit: 3 of 5 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Patricia Young, Community Complaint Investigator

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

5/2/2023
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 03/08/2023

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

(1) The care and services identified in the negotiated care plan.

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

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

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure 1 of 6 residents (Resident 1) was repositioned in bed every two hours as required per their Negotiated Care Plan (NCP). This failure contributed to pressure injuries (open areas to the skin from continuous pressure) to Resident 1's skin and a decreased state of well-being.

Findings included...

Record review showed the AFH admitted Resident 1 to the AFH on [redacted] 2020 with multiple diagnoses including [redacted]). Review of Resident 1's NCP, dated 09/22/2022, showed caregivers were required to check Resident 1's skin for any changes at least once a day. The NCP showed that the caregivers were required to assist Resident 1 to change positions at least every two hours.

Review of Resident 1's assessment, dated 01/06/2023, showed Resident 1 was totally dependent on the caregivers for bed mobility. The assessment showed caregivers were required to reposition or turn in bed Resident 1 every two hours. The assessment showed Staff A (Entity Representative) checked Resident 1's skin daily and reported Resident 1 did not have any skin issues.

Record review of Resident 1's hospital medical records, dated [redacted] 2023, showed that Resident 1 was transported to the emergency room, on 03/06/2023, for blood in the urine and Resident 1's urinary catheter was not working properly. Resident 1's hospital medical records showed that Resident 1 was transferred and admitted to an inpatient hospital on [redacted] 2023 for septic shock (life-threatening condition defined by dangerously low blood

pressure leading to multiple organ failure following an infection).

Review of Resident 1's hospital wound consultation records, dated 03/08/2023, showed Resident 1 had the following skin wounds:

- 2.4 centimeter (cm) by 1.9 cm pressure injury to the middle of their buttocks
- 1 cm by 1.5 cm unstageable (full-thickness skin and tissue loss, bottom of wound unable to diagnose) pressure injury to their left lower buttock
- scab to their upper, inner, left buttock
- 3.5 cm by 3.7 cm pressure injury to their right heel

During an interview, on 03/27/2023 at 12:18 PM, Staff A (Entity Representative) stated that Resident 1 could not turn or reposition themselves in bed beginning 01/01/2023. Staff A stated they knew Resident 1 had to be turned every two hours. Staff A stated that Resident 1 was approximately repositioned every four hours. Staff A stated that Resident 1 was transferred to bed at 10:00 PM each night and not repositioned until 06:00 AM the following morning. Staff A stated that Resident 1 was not turned every two hours as required by the assessment and NCP. Staff A stated that Resident 1 told caregivers not to bother them overnight and refused turning during the day. Staff A stated that they noticed a change in the skin color of Resident 1's right heel, on 03/05/2023, but did not notice any other skin changes. Staff A stated that the skin change in Resident 1's right heel was not reported to the doctor because Resident 1 went to the hospital on 03/06/2023.

During an interview, on 03/27/2023 at 03:35 PM, Collateral Contact 3 (CC3) (Resident 1's Representative) stated that they were shocked when hospital told them about Resident 1's pressure injuries. CC3 stated that Resident 1 would not be going back to the AFH.

During an interview, on 03/29/2023 at 11:20 AM, Resident 1 stated that caregivers did not turn them enough at the AFH. Resident 1 stated that caregivers waited too long in between turning or moving them. Resident 1 stated that they did not tell caregivers not to bother them overnight. Resident 1 stated that they did not get enough attention at the AFH which made them feel bad.

During an interview on 04/28/2023 at 10:11 AM, Staff B (Caregiver) stated that they did not provide hands-on care to Resident 1. Staff B stated they assisted Staff A and C (Resident Manager) and did not provide direct care to any residents. Staff B stated they did not know Resident 1 had wounds.

During an interview on 04/28/2023 at 10:17 AM, Staff C (Resident Manager) stated they did not know Resident 1 had wounds. Staff C stated that they turned Resident 1 four to five times a day during the day. Staff C stated that they did not turn Resident 1 overnight because Resident 1 refused to be turned.

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, Faithful Passion Care LLC is or will be in compliance with this law and / or regulation on (Date) 06/09/23 .

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

Provider (or Representative) — Date: 05/08/2023

WAC 388-76-10225 Reporting requirement.

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

(b) The resident's representative, if one exists;

(c) The resident's health care provider;

(d) Other appropriate professionals working with the resident;

(f) The resident's case manager if the resident is a department client.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure pressure injuries (open areas to the skin from continuous pressure) for 1 of 6 residents (Resident 1) were reported to Resident 1's representative, case manager, nurse delegator, and health care provider. These failures resulted in a delay in specialized pressure injury treatment.

Findings included...

Record review showed the AFH admitted Resident 1 to the AFH on [redacted]/2020 with multiple diagnoses including [redacted].

Record review of Resident 1's hospital medical records, dated [redacted]/2023, showed that Resident 1 was transported to the emergency room, on 03/06/2023, for blood in the urine and Resident 1's urinary catheter was not working properly. Resident 1's hospital medical records showed that Resident 1 was transferred and admitted to an inpatient hospital on [redacted]/2023 for septic shock (life-threatening condition defined by dangerously low blood pressure leading to multiple organ failure following an infection).

Review of Resident 1's hospital wound consultation records, dated 03/08/2023, showed Resident 1 had the following skin wounds:

- 2.4 centimeter (cm) by 1.9 cm pressure injury to the middle of their buttocks.
- 1 cm by 1.5 cm unstageable (full-thickness skin and tissue loss, bottom of wound unable to diagnose) pressure injury to their left lower buttock
- scab to their upper, inner, left buttock
- 3.5 cm by 3.7 cm pressure injury to their right heel

During an interview, on 03/24/2023 at 02:21 PM, Collateral Contact 1 (CC1) (Resident 1's Home and Community Services Case Manger) stated that Staff A (Entity Representative) did not report Resident 1 had any pressure injuries or skin issues at any time during Resident 1's stay at the AFH. CC1 stated that they showed Staff A photographed examples of pressure injuries to aid in identifying any skin issues. CC1 stated that Staff A said Resident 1 did not have any skin issues.

During an interview, on 03/27/2023 at 12:18 PM, Staff A stated that they noticed a change in the skin color of Resident 1's right heel, on 03/05/2023, but did not notice any other skin changes. Staff A stated that the skin change in Resident 1's right heel was not reported to the doctor because Resident 1 went to the hospital on 03/06/2023.

During an interview, on 03/27/2023 at 03:14 PM, Collateral Contact 2 (CC2) (Nurse Delegator) stated that Staff A did not report Resident 1 had any pressure injuries or skin issues at any time during Resident 1's stay at the AFH. CC2 stated that they would have started a special skin program for Resident 1 if skin issues or injuries were reported.

During an interview, on 03/27/2023 at 03:35 PM, Collateral Contact 3 (CC3) (Resident 1's Representative) stated that Staff A did not tell them Resident 1 had open areas to their skin. CC3 stated that the hospital staff notified them of Resident 1's pressure injuries on [redacted]/2023 when Resident 1 was admitted to the hospital. CC3 stated that they were shocked when they were told about Resident 1's pressure injuries. CC3 stated that Resident 1 would not be going back to the AFH.

During an interview on 04/28/2023 at 10:17 AM, Staff C (Resident Manager) stated they did not know Resident 1 had wounds. Staff C stated they did not notify anyone that Resident 1 refused to be turned.

Attestation Statement

Statement of Deficiencies	License #: 754257	Compliance Determination # 21570
Plan of Correction	Faithful Passion Care LLC	Completion Date
Page 6 of 6	Licensee: Faithful Passion Care LLC	04/25/2023

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, Faithful Passion Care LLC is or will be in compliance with this law and / or regulation on (Date) 06/09/2023 .

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

Provider (or Representative) — Date: 05/08/2023