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

6/12/2024

Holy Land AFH LLC

Holy Land AFH LLC
8804 78th Dr NE
Marysville, WA 98270

RE: Holy Land AFH LLC License # 755502

Dear Provider:

This letter addresses Compliance Determination(s) 42480 (Completion Date 06/12/2024) and 39682 (Completion Date 04/22/2024).

The Department completed a follow-up inspection of your Adult Family Home on 06/12/2024 and found that you have corrected the violations listed in the Full report dated 04/22/2024. Your home is back in compliance as of 05/30/2024 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 388-76-10522-6, WAC 388-76-10532-2-c

The Department staff who did the off-site verification:
Toni Bolo, 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

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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 the unannounced on-site full inspection on 04/11/2024 and 04/11/2024 of:
Holy Land AFH LLC
8804 78th Dr NE
Marysville, WA 98270

The following sample was selected for review during the unannounced on-site visit: 2 of 5 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Toni Bolo, 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

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 388-76-10522 Resident rights Notice Policy on accepting medicaid as a payment source. The adult family home must fully disclose the home's policy on accepting medicaid or other public funds as a payment source. The policy must:

(6) Be signed and dated by the resident and kept in the resident record after signature.

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure 5 of 5 resident's (Resident 1, 3, 4, 5, & 6) records had a signed and dated copy of the AFH's policy on accepting Medicaid as a payment source. This failure placed the residents at risk of not being fully informed of their rights or understanding the AFH's Medicaid policy.

Findings included…

Record review showed the AFH admitted Resident 1 on [redacted]/2023. Resident 1's record did not contain a signed and dated copy of the AFH's Medicaid policy.

Record review showed the AFH admitted Resident 3 on [redacted]/2022. Resident 3's record did not contain a signed and dated copy of the AFH's Medicaid policy.

Record review showed the AFH admitted Resident 4 on [redacted]/2022. Resident 4's record did not contain a signed and dated copy of the AFH's Medicaid policy.

Record review showed the AFH admitted Resident 5 on [redacted]/2022. Resident 5's record did not contain a signed and dated copy of the AFH's Medicaid policy.

Record review showed the AFH admitted Resident 6 on [redacted]/2023. Resident 6's record did not contain a signed and dated copy of the AFH's Medicaid policy.

Interview on 04/11/2024 at 1:45 PM, Staff B (Entity Representative) stated that the AFH had a Medicaid Policy and that they were not aware the five current residents did not have copies of the signed and dated AFH Medicaid Policy forms in their records.

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, Holy Land AFH 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 388-76-10532 Resident rights Department standardized disclosure forms.

(2) The adult family home must complete the disclosure of charges form as provided by the department. The home must:

(c) Keep a copy that has been signed and dated by the resident in the resident's record.

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure that 5 of 5 residents (Resident 1, 3, 4, 5, & 6) had a signed and dated disclosure of charges form in their record. This failure placed the residents at risk of not being fully informed of the fees charged by the AFH.

Findings included…

Record review showed the AFH admitted Resident 1 on [redacted]/2023. A disclosure of charges form was not found in Resident 1's record.

Record review showed the AFH admitted Resident 3 on [redacted]/2022. A disclosure of charges from was not found in Resident 3's record.

Record review showed the AFH admitted Resident 4 on [redacted]/2022. A disclosure of charges form was not found in Resident 4's record.

Record review showed the AFH admitted Resident 5 on [redacted]/2022. A disclosure of charges form was not found in Resident 5's record.

Record review showed the AFH admitted Resident 6 on [redacted]/2023. A disclosure of charges from was not found in Resident 6's record.

Interview on 04/11/2024 at 1:45 PM, Staff B (Entity Representative) stated that they were

not aware that the disclosure of charges forms had not been completed for any of the current AFH residents.

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, Holy Land AFH 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