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

Federal Way Senior Care LLC

Federal Way Senior Care LLC
4127 SW 327th Pl
Federal Way, WA 98023

RE: Federal Way Senior Care LLC License # 755507

Dear Provider:

This letter addresses Compliance Determination(s) 50655 (Completion Date 12/18/2024) and 45539 (Completion Date 09/23/2024).

The Department completed a follow-up inspection of your Adult Family Home on 12/18/2024 and found that you have corrected the violations listed in the Complaint report dated 09/23/2024. Your home is back in compliance as of 09/15/2024 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 388-76-10673-1-a, WAC 388-76-10673-2-a, WAC 388-76-10673-2-b, WAC 388-76-10673-2, WAC 388-76-10380-1, WAC 388-76-10380-2

The Department staff who did the on-site verification:
Jennifer Domingo, AFH Complaint Investigator

If you have any questions, please contact me at (253)234-6033.

Sincerely,

Cecile Leano, Field Manager
Region 2, Unit E
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
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20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 755507	Compliance Determination # 45539
Plan of Correction	Federal Way Senior Care LLC	Completion Date
Page 1 of 6	Licensee: Federal Way Senior Care LLC	09/23/2024

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 08/13/2024 and 08/13/2024 of:

Federal Way Senior Care LLC
4127 SW 327th Pl
Federal Way, WA 98023

This document references the following complaint number(s): 140745

The following sample was selected for review during the unannounced on-site visit: 4 of 4 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Domingo, AFH Complaint Investigator

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 _____ 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 388-76-10673 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 observation, interview, and record review, the Adult Family Home (AFH) failed to report to the Department Complaint Resolution Unit (CRU [Department hotline]) when 3 of 3 residents (Resident 1, 2, and 3) had an incident of suspected abuse and a resident-to-resident altercation. The AFH failed to report to the Law Enforcement (LE) when Resident 1 assaulted Resident 2. This failure placed a delayed investigations and the residents at risk for unrecognized abuse/neglect and unmet care needs.

Findings included…

Review of the AFH undated policy titled, “MANDATORY REPORTING…ABUSE, NEGLECT…OF ANY RESIDENT”, showed the, “Facility provider, entity representative, resident manager, caregiver, staff…that provide care and services to residents are mandatory reporters and must report to the department when there is the following: Physical Abuse: Physical abuse may include, but is not limited to the following: kinking, squeezing, pinching, slapping, striking with or without an object, pushing and the use of excessive force when restraining an agitated client…All AFH providers, entity representatives, resident managers, owners, caregivers, staff and students that provide care and services to residents, if they suspect sexual or physical assault to have occurred are mandated reporters and must report to: 3. TOLL FREE TELEPHONE NUMBER: 1800-562-6078 HOTLINE. 4. THE APPROPRIATE LAW ENFORCEMENT AGENCIES “.

On 08/13/2024 at 2:38 PM, observation showed two staff members (Staff B, Caregiver and Staff C, Caregiver) and four residents (Residents 1, 2, 3, and 4) in the AFH during

the department staff's unannounced visit.

Incident 1
Review of the AFH Incident report (IR) dated 06/15/2024, at 12:30 PM, showed Resident 1 unprovokedly slapped Resident 2 on the head at the bathroom door. IR showed staff separated them immediately and removed Resident 1 from the scene. IR showed CRU and LE were not notified of the incident. The IR did not indicate ruling out (exclude, eliminate) abuse or neglect.

In an interview with Resident 2, on 08/13/2024 at 2:23 PM, they stated that Resident 1, in their opinion, was "too aggressive" and that Resident 1 punched them in the eye. Resident 2 stated that they had a bowel accident and went to the bathroom to take a shower; on their way to the bathroom, they saw the bathroom door was partially open; they thought it was vacant. Resident 2 stated that Resident 1 was in the bathroom. Resident 2 knocked on the bathroom door and explained to Resident 1 to close it so they could have privacy. Then, "out of nowhere," Resident 1 hit them on their left eye. Resident 2 stated that Resident 1 was mad and told them that the bathroom was theirs and that they owned the home. Resident 2 stated that they felt unsafe at that time. Resident 2 stated that they called LE the next day, and LE came to the home. Resident 2 stated that LE told them they could not do anything about Resident 2 because of their mental health condition. Resident 2 stated that Resident 1 was their friend the day before Resident 1 hit them.

In a telephone interview with Staff A, Entity Representative, on 08/13/2024 at 2:55 PM, stated that they did not report the incident to CRU because they were unsure if the incident really occurred. Staff A stated that Staff B, who was on duty when the incident occurred, was in the kitchen and heard a commotion in the bathroom; when Staff B got to the scene, Residents 1 and 2 were standing in the hallway by the bathroom, and Resident 2 reported that Resident 1 hit them. Staff B stated that they did not witness Resident 1 hit Resident 2. Staff A stated that Resident 2 had no injury and Resident 2 did not like Resident 1. Staff A stated that they were not sure if the incident had happened because Resident 2 gets fixated on things that were not true. Staff A stated that they needed to observe if the incident did happen or not for them to call CRU.

In a telephone interview with Staff A on 09/19/2024 at 4:16 PM, they stated that they did not call LE on the 06/15/2024 incident because they were not sure if the incident did occur. Staff A stated that Resident 2 reported they were hit by Resident 1 after the incident happened. Staff A stated that Resident 2 did call the LE early in the morning of 06/16/2024, not because of the incident but because Resident 2 heard Resident 1 from their bedroom in the hallway, walked by their bedroom, and Resident 2 thought Resident 1 was going to their bedroom. Staff A stated that they suspected Resident 1 did hit Resident 2 but was not sure if the case was valid.

Incident 2
Review of the AFH IR dated 07/26/2024, at 2:00 PM, showed Resident 1 wandered off to Resident 3’s bedroom and slapped Resident 3’s face before staff could reach them. IR showed the facility did not notify the CRU of the resident-to-resident altercation

incident. IR showed abuse or neglect was not ruled out.

In an interview with Staff B on 08/13/2024 at 2:11 PM, Staff B stated that Resident 1 had "Dementia" (a term for a group of symptoms affecting memory, thinking and social abilities), went to Resident 3's bedroom and asked them what they were doing in their room. Staff B stated that Resident 1 thought Resident 3's bedroom was theirs. Staff B stated that Resident 1 slapped Resident 3 with a slipper. Staff B stated that before Resident 1 hit Resident 3 again, they removed Resident 1 from Resident 3's bedroom. Staff B stated that Resident 3 could not walk; they used a wheelchair and defended themselves by using their arm. Staff B stated that they did not report the incident to CRU because they immediately separated Resident 1 and 3. They sorted out the incident, and both residents had no injuries.

In an interview with Resident 3 on 08/13/2024 at 3:02 PM, Resident 3 stated that Resident 1 slapped them on the face and that they didn't know why.

In a telephone interview on 09/18/2024 at 3:48 PM, Staff A admitted that they missed notifying CRU of Resident 1 and 3's resident-to-resident altercation on 07/26/2024. Staff A stated that it did not click in their mind that they had to call CRU.

Review of a department record-keeping system showed the home had no report of any resident-to-resident altercation incidents on Resident 1, 2, and 3.

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, Federal Way Senior Care 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 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(1) After an assessment for a significant change in the resident's physical or mental condition;

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the Adult Family Home (AFH) failed to update and review the Negotiated Care Plan (NCP) for 3 of 3 residents (Residents 1, 2, and 3). This failure placed the residents at risk of unmet care needs, harm and repeated resident-to-resident altercations.

Findings included…

RESIDENT 1
Review of the AFH Incident report (IR) dated 06/15/2024, at 12:30 PM, showed Resident 1 had a resident-to-resident altercation with Resident 2. IR showed Resident 1 slapped Resident 2's head. IR showed the incident occurred at the bathroom door. IR showed staff separated them immediately and removed Resident 1 from the scene. IR showed "Safety measure: TO ENSURE THE TWO ARE NOT TOGETHER ALONE."

Review of the AFH IR dated 07/26/2024, at 2:00 PM, showed Resident 1 wandered off to Resident 3's bedroom and slapped Resident 3's face before staff could stop NR 1. IR showed, "Safety measure: Remove from harm", the designated box was checked.

Record review of Resident 1's assessment dated 06/04/2024, showed the following behaviors: "Client wanders around the AFH and will go into other residents and caregiver's room". The assessment showed a personalized interventions to keep Resident 1in caregiver's sight and redirect them when they attempt to go into other residents and caregivers' room.

Record review of Resident 1's NCP dated 05/01/2024 under the section, "PSYCH/SOCIAL/COGNITIVE STATUS", did not show an intervention for caregivers to keep Resident 1 in their sight and redirected them when they attempted to go into other residents' bedroom intervention as indicated on their current assessment. NCP showed the incidents on 06/15/2024 and 07/26/2024 regarding resident-to-resident altercations between Resident 1 and Resident 2 and 3 were not addressed and updated. NCP showed no interventions were noted to decrease the risk of Resident 1 assaulting other residents.

In a telephone interview with Staff A, Entity Representative, on 09/15/2024 at 4:54 PM, they stated that they did not know Resident 1 NCP needed to be updated.

RESIDENT 2
Review of the AFH IR dated 06/15/2024, at 12:30 PM, showed Resident 2 was slapped by Resident 1 on their head. Staff B, Caregiver, separated the two residents immediately. Staff B removed Resident 1 from the scene.

Record review of Resident 2's NCP dated 06/09/2024, was signed by Resident 2 on

06/24/2024. NCP showed no incidents and preventative measures were documented about the resident-to-resident altercations between Resident 2 and 3.

In a telephone interview with Staff A on 09/15/2024 at 4:54 PM, stated that they did not know Resident 2 NCP needed to be updated.

RESIDENT 3
Review of AFH IR dated 07/26/2024, at 2:00 PM, showed Resident 1 wandered to Resident 3's bedroom. IR showed Resident 3 was slapped by Resident 1 on the face with a slipper before Staff B could stop NR 1.

Record review of Resident 3's NCP dated 06/26/2024, was signed by Resident 3's Representative on 06/26/2024. The NCP was not updated to address the incident and preventative measures of Resident 1 wandering to Resident 3 and slapping them.

In a telephone interview with Staff A on 09/15/2024 at 4:54 PM, stated that they did not know Resident 3 NCP needed to be updated.

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, Federal Way Senior Care 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