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

01/29/2024

Amboseli Adult Family Home LLC
Amboseli Adult Family Home LLC
29813 20th Ave S
Federal Way, WA 98003

RE: Amboseli Adult Family Home LLC # 755707

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 35942 (Completion Date 01/29/2024) and 28946 (Completion Date 09/29/2023).

The Department completed a follow-up inspection of your Adult Family Home on 01/29/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10615 Resident rights Transfer and discharge.

(3) The home must give residents enough preparation and orientation to ensure a safe and orderly transfer or discharge from the home.

The Department staff who did the On Site verification:
Mavis Downing, NCI

If you have any questions, please contact me at (253)234-6007.

Sincerely,

Lydia Owusu-Acheampong, Field Manager
Region 2, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Amboseli Adult Family Home LLC
Provider Type: Adult Family Home
License/Cert.#: 755707
Intake ID: 97193
Compliance Determination #: 28946
Region/Unit #: RCS Region 2 / Unit G
Investigator: Mavis Downing
Investigation Date(s): 09/01/2023 through 09/29/2023
Complainant Contact Date(s):

Allegation(s):

1. Named Resident (NR) was kicked out of the Adult family Home (AFH) and send out to a Local Health Facility (LHF)
2. The AFH staff went trough all the residents clothes and put the clothes outside of the home on the lawn.
3. NR did not take medications for 7-8 days and did not eat anything.

Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 3 Closed records sample size:
Observations:	Residents Staff
Interviews:	Residents Staff
Record Reviews:	Assessments Negotiated Care Plan (NCP)

Investigation Summary:

1. Observation on 09/01/2023 showed NR was not in the home. In an interview, the AFH staff stated that the NR was out for a medical appointment.
Observation on 09/04/22023 at 11:00 AM showed NR was not in the home. In an interview, AFH staff stated that NR was no longer a resident of the home and that, the NR had been discharged from the home.
The AFH staff stated that they had issued a 30 day notice dated [redacted]/2023 for the NR to vacate the home due to non-compliance with medication, aggressive behavior and refusal to pay participation.
In the interview on 09/07/2023, NR stated that they were denied entry into the home in the early hours of [redacted]/2023 after being discharged from a Local Health Facility, after a short stay.
The NR stated that, they spend three days and two nights sleeping outside the home without food and water and staff did not assist them with medication administration.
The resident stated that on the morning of 09/04/2023, the resident experienced a

change in condition and asked the AFH Caregiver to arrange transportation to a LHF.
The AFH failed to ensure NR was safely discharged from the AFH constituted failed practice.
Please refer to WAC 388-76-10615 (3) dated 09/29/2023.
2. In an interview, AFH staff confirmed they put the NR's property including clothing outside of the home, as the NR was discharged from the home. Staff denied having gone through the resident's clothes.
3. In an interview, NR stated that they did not take medications for 7-8 days or eat anything.
Review of the Medication administration Record (MAR) May 2023 to August 2023, showed, NR refused to take medications on multiple occasions.
In an interview, AFH staff stated that the resident did not take their medications consistently.
AFH Staff notified the resident's doctor and the case manager when the NR refused to take medications.
In an interview on 09/07/2023, NR stated that AFH staff provided meals when the NR resided in the home, but AFH staff did not provide meals or water since [redacted]/2023, when the resident was denied entry to the AFH.

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: Amboseli Adult Family Home LLC
Provider Type: Adult Family Home
License/Cert.#: 755707
Intake ID: 95395
Compliance Determination #: 28946
Region/Unit #: RCS Region 2 / Unit G
Investigator: Mavis Downing
Investigation Date(s): 09/01/2023 through 09/29/2023
Complainant Contact Date(s):

Allegation(s):

1. AFH staff were disrespectful to the resident.
2. Staff accused NR of being a liar
3. NR received a 30 day notice to vacate the home as staff were unable to handle the resident's care. The resident did not know the discharge date as staff moved the resident's documents.
4. Staff had a party for their friends there was noise in the room until 1:00 AM.
5. NR was not served any food and had to ask for dinner. Staff made hot pockets for the resident. The resident requested for food but staff did not know how to cook the food the resident requested.
6. The resident was sleeping in the couch and Staff woke up the resident by screaming in the resident's face because the TV was too loud.
7. Staff took the resident's marijuana's vape (electric smoking pipe) because staff think the resident will burn the house.

Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 3 Closed records sample size:
Observations:	Residents Staff Environment
Interviews:	Residents Staff
Record Reviews:	Assessment Negotiated MAR/TAR Plan (NCP) 30 day Notice medical Record physician's Orders.

Investigation Summary:

1. Observation showed, NR was not in the home. The NR was out for medical appointment. Observation showed staff providing care and interacting with the

residents in a dignified manner. In interview, staff denied being disrespectful to the NR. In interview, sampled residents denied abuse or neglect.
2. In interview, staff denied accusing NR of being a liar. In interview, sampled residents denied staff accusing them of being liars.
3. In an interview, staff confirmed they issued a 30 day notice dated [redacted]/2023 for the NR to vacate the home and stated they were going to assist the NR to locate the notice or staff were going to provide another copy of the notice to the NR and ensure the NR knew the discharge date.
4. In interview, staff denied having a party in the home. In interview, sampled residents denied experiencing noise and stated they did not observe any staff party in the home.
5. In the interview, NR stated that, staff prepared food for them when they resided in the home as required. In interview, sampled residents stated they were satisfied with food staff prepared for them.
6. In interview, staff denied screaming in the NR's face while the NR was sleeping in the couch. In interview, sampled residents denied any verbal or mental abuse.
7. In interview, staff denied getting the marijuana vape from the resident.

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

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 09/01/2023 and 09/04/2023 of:

Amboseli Adult Family Home LLC
29813 20th Ave S
Federal Way, WA 98003

This document references the following complaint number(s): 96177, 97193, 95395

The following sample was selected for review during the unannounced on-site visit: 3 of 4 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Mavis Downing, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit G
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.

Dahl Kim — Residential Care Services

10/13/2023 — 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.

Statement of Deficiencies	License #: 755707	Compliance Determination # 28946
Plan of Correction	Amboseli Adult Family Home LLC	Completion Date
Page 2 of 4	Licensee: Amboseli Adult Family Home LLC	09/29/2023

MERCY KARIUKI
Provider (or Representative)

10/13/2023
Date

WAC 388-76-10615 Resident rights Transfer and discharge.

(3) The home must give residents enough preparation and orientation to ensure a safe and orderly transfer or discharge from the home.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to give 1 of 4 residents (Resident 1) enough preparation for a safe discharge. This failure resulted in Resident 1 spending three days and two nights outside of the AFH after being denied entry, placing Resident 1 at risk of worsening health conditions and medical complications from not receiving necessary care.

Findings included...

During a visit on 09/01/2023 at 11:00 AM, observation and interview showed three residents (Resident 2, 3, & 4), and Staff A, Entity Representative/Resident Manager, Staff B and C (both Caregivers) providing care for the residents. Staff A, Entity Representative/Resident Manager, stated that they had a total of four residents in the home including Resident 1 who was out for a medical appointment. Staff A added that Resident 1 was expected to return to the home in a couple of hours.

Review of Resident 1's assessment, dated 07/03/2023, showed the AFH admitted Resident 1 on [redacted]/2023 with multiple diagnoses including [redacted]. This assessment showed Resident 1 was alert and oriented and able to walk independently without assistance of a caregiver. Review of Resident 1's negotiated care plan dated 05/23/2023 showed, Resident 1 required assistance with meal preparation, and medication administration which included the use of insulin (an injectable solution used to manage blood sugar levels).

Review of Resident 1's Medication Log for the months of May, June, July, and August 2023 showed Resident 1 refused medication administration on multiple occasions since admission to the AFH, including isoniazid [a medication used to manage and suppress tuberculosis (TB, an infection mainly affecting the lungs)].

In an interview during the second on-site on 09/04/2023 at 11:55 AM, Staff A stated that they sent Resident 1 to the hospital on [redacted]/2023 at 5:00 PM, for TB evaluation per recommendation from the Local Health Jurisdiction. Staff A added that Staff A went to the hospital's emergency department on the same day at 6:00 PM where Resident 1 was being evaluated, and served Resident 1 a discharge notice, dated [redacted]/2023. Staff A stated that Resident 1 refused to sign the discharge notice. Staff A stated that they left the discharge notice with the emergency department staff and informed the emergency department staff to not discharge Resident 1 back to the AFH. Staff A stated that on [redacted]/2023 just after midnight, Resident 1 knocked on the main entrance of the AFH after returning from the

emergency department. Staff A said they did not allow Resident 1 to enter the AFH.

In an interview, on [redacted]/2023 at 12:00 PM, Staff A reported Resident 1 was taken by ambulance on [redacted]/2023. When asked for the reasons Staff A denied Resident 1 entry into the AFH, Staff A stated that it was due to Resident 1's behaviors, refusal to take medications, and refusing to pay the monthly participation fee.

In two telephone interviews, on 09/07/2023 at 10:30 AM, and 09/25/2023 at 2:00 PM, Resident 1 stated that, they returned to the AFH from the emergency department in the early hours of [redacted]/2023, found their belongings (which included a sleeping bag) outside on the lawn, near the patio. After being denied entry into the home, Resident 1 slept in a sleeping bag, on the covered patio located behind the home leading to the main entrance of the home. Resident 1 stated that the AFH Staff did not provide any food, water, alternative accommodations, or assistance to administer their medications, which included their insulin. Resident 1 stated that they were very hungry, and they did not have any money on them.

Review of recorded emergency services (911) calls from 08/31/2023-[redacted]/2023, showed Staff A contacted the Local Law Enforcement (LLE) multiple times to request assistance in removing Resident 1 from the AFH property. Staff A is heard telling the LLE that the resident was no longer a resident of the AFH.

Continued review of recorded 911 calls made by the AFH between [redacted]2023 – [redacted]/2023, the LLE was heard notifying Staff A that, the LLE was unable to go onsite, and they are unable to make Resident 1 leave the home premises, as the AFH was Resident 1's primary residence.

* Please resend clear Summary Paragraph ✓

In summary, Resident 1 was living in the AFH on [redacted]/2023 and was sent to the hospital for an evaluation not related to a change in condition. Resident 1 was not admitted to the hospital and was at the same functional level upon returning to the AFH. When Resident 1 returned from the hospital on [redacted]/2023, the AFH denied entry into the AFH. Resident 1 was not given the opportunity to arrange an orderly discharge which resulted in Resident 1 sleeping outside of the AFH until the morning of [redacted]/2023. *

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, Amboseli Adult Family Home LLC is or will be in compliance with this law and / or regulation on (Date) 10/13/2023.

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

Provider (or Representative) MERCY KARIUKI Date 10/13/2023

emergency department. Staff A said they did not allow Resident 1 to enter the AFH.

In an interview, on [redacted]/2023 at 12:00 PM, Staff A reported Resident 1 was taken by ambulance on [redacted]/2023. When asked for the reasons Staff A denied Resident 1 entry into the AFH, Staff A stated that it was due to Resident 1's behaviors, refusal to take medications, and refusing to pay the monthly participation fee.

In two telephone interviews, on 09/07/2023 at 10:30 AM, and 09/25/2023 at 2:00 PM, Resident 1 stated that, they returned to the AFH from the emergency department in the early hours of [redacted]/2023, found their belongings (which included a sleeping bag) outside on the lawn, near the patio. After being denied entry into the home, Resident 1 slept in a sleeping bag, on the covered patio located behind the home leading to the main entrance of the home. Resident 1 stated that the AFH Staff did not provide any food, water, alternative accommodations, or assistance to administer their medications, which included their insulin. Resident 1 stated that they were very hungry, and they did not have any money on them.

Review of recorded emergency services (911) calls from 08/31/2023- [redacted]/2023, showed Staff A contacted the Local Law Enforcement (LLE) multiple times to request assistance in removing Resident 1 from the AFH property. Staff A is heard telling the LLE that the resident was no longer a resident of the AFH.

Continued review of recorded 911 calls made by the AFH between [redacted]2023 – [redacted]/2023, the LLE was heard notifying Staff A that, the LLE was unable to go onsite, and they are unable to make Resident 1 leave the home premises, as the AFH was Resident 1's primary residence.

In summary, Resident 1 was living in the AFH on [redacted]/2023 and was sent to the hospital for an evaluation not related to a change in condition. Resident 1 was not admitted to the hospital and was at the same functional level upon return to the AFH. When Resident 1 returned from the hospital on [redacted]/2023, the AFH denied entry into the AFH. Resident 1 was not given the opportunity to arrange an orderly discharge which resulted in Resident 1 sleeping outside of the AFH until the morning of [redacted]/2023.

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, Amboseli Adult Family Home 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

Statement of Deficiencies	License #: 755707	Compliance Determination # 28946
Plan of Correction	Amboseli Adult Family Home LLC	Completion Date
Page 4 of 4	Licensee: Amboseli Adult Family Home LLC	09/29/2023