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

Hannah's Serene AFH LLC

Hannah's Serene AFH LLC
19250 106th Ave SE
Renton, WA 98055

RE: Hannah's Serene AFH LLC License # 755744

Dear Provider:

This letter addresses Compliance Determination(s) 32516 (Completion Date 11/14/2023) and 26560 (Completion Date 10/06/2023).

The Department completed a follow-up inspection of your Adult Family Home on 11/14/2023 and found that you have corrected the violations listed in the Complaint report dated 10/06/2023. Your home is back in compliance as of 10/13/2023 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 388-76-10400-3-b

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

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

Sincerely,

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Hannah's Serene AFH LLC **Provider Type:** Adult Family Home

License/Cert.#: 755744
Intake ID: 88751
Compliance Determination #: 26560
Region/Unit #: RCS Region 2 / Unit E
Investigator: Jennifer Domingo
Investigation Date(s): 07/12/2023 through 10/06/2023
Complainant Contact Date(s): 07/12/2023

Allegation(s):
The Former Resident (FR) and Named Resident (NR) had repeated falls in the Adult Family Home (AFH).

Investigation Methods:

Sample:	Total residents: 3 Resident sample size: 3 Closed records sample size: 1
Observations:	General environment, residents' appearance, staff to residents interaction and resident to resident interaction.
Interviews:	Residents and staff
Record Reviews:	Residents and AFH records

Investigation Summary:
Observation showed there were three residents and two staff in the home during the unannounced visit. Observation showed NR was able to propel themselves in the wheelchair using their feet. Observation showed FR was not in the home. Staff stated that FR passed away in [redacted] 2023. FR was admitted to the AFH on Hospice care (medical care designed for people with a serious illness who are approaching end of life.) and was given five months to live. Staff stated that FR was initially mobile until they had multiple falls because they continued to decline in their medical condition. Staff stated that Hospice visited FR regularly and was informed of their falls. NR was admitted to the home and was a high fall risk because of their poor safety judgement and medical condition. Record review showed NR had 21 non-injury falls from April to June 2023 that did not require hospitalization. Staff stated that they notified NR's primary care, HH therapist and their representative of NR's repeated falls. Staff stated that NR admitted to them with increased weakness and was adjusting to new environment. Staff stated that NR did not know their limitations of what they could do for themselves. But NR's strength improved with Home Health ([HH] skilled care delivered directly to a patient's home provided by license medical professionals such as nurses, therapists, and aides.) Therapy (exercises are focused on restoring functional mobility to be able to activities of daily living without falls or injuries). NR stated that

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they thought they could do everything for themselves such as transfer or walk without assistance. NR and other current residents denied abuse and neglect in the home. NR denied anyone pushed them when they fell. NR stated they had no further falls in the home. Staff stated that NR had no further fall after June 2023. NR and other current residents stated that they had no concerns about their safety, care, or services in the AFH. Staff stated that they thought they did everything they could to keep NR safe.

Failed Provide practice identified. See Statement of Deficiencies dated 10/06/2023. WAC 388-76-10400 Care and Services. (3)(b)

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 755744	Compliance Determination # 28680
Plan of Correction	Hannah's Serene AFH LLC	Completion Date
Page 1 of 4	Licensee: Hannah's Serene AFH LLC	10/06/2023

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 07/12/2023 and 07/13/2023 of:

Hannah's Serene AFH LLC
19250 106th Ave SE
Renton, WA 98055

This document references the following complaint number(s): 68751

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

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STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

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

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Hannah's Serene AFH LLC
19250 106th Ave SE
Renton, WA 98055

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Residential Care Services

Date

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Ruth Kihara
Provider (or Representative)

10/13/2023
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:

(c) Actively supports the safety of each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to ensure 1 of 1 resident (Resident 1) who had multiple falls received the care and services to keep them safe. This failure placed Resident 1 at risk for harm or injury from multiple falls they had within three months.

Findings included...

On 07/12/2023 at 2:57 PM, observation showed Resident 1 in the AFH sitting in their wheelchair, alert and verbally conversant. Observation showed Resident 1 was able to propel themselves in the wheelchair using their feet.

Record review of the assessment, dated 04/12/2023, showed that Resident 1 had history of three falls within the last six months. Assessment showed that Resident 1 had diagnoses of [redacted] and [redacted].

Review of the hospital record, dated 04/12/2023, showed that Resident 1 had admission diagnoses of [redacted] and [redacted]. Hospital records showed that Resident 1 was a fall risk.

Record review of the AFH notes showed that Resident 1 was admitted on [redacted]/2023 from

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Provider (or Representative) _____ Date _____

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Record review of the AFH notes showed that Resident 1 was admitted on [redacted]/2023 from

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the hospital. AFH notes showed that the resident was a high risk of falls.

Review of Resident 1's Incident log (IL), and Incident notes showed the following: 1) Non-injury fall on 04/17/2023. Resident 1 fell in room trying to get his water. 2) Non-injury fall on 04/18/2023. Fall from bed. Wanted to do things for self. 3) Non-injury fall on 04/21/2023. Resident 1 fell from bed wanted to get snack. 4) Non-injury fall on 04/29/2023 fall from commode self-transfer. 5) Non-injury fall on 04/30/2023. Resident 1 slid from bed. 6) Non-injury fall on 05/06/2023. Resident 1 fell while with Physical Therapist ([PT] is therapy that is used to preserve, enhance or restore movement and physical function impaired or threatened by disease, injury or disability and that utilizes therapeutic exercise, physical modalities (such as massage) assistive devices, and patient education and training). 7) Non-injury fall on 05/07/2023. Resident 1 was found on the floor by staff. 8) Non-injury fall on 05/19/2023. Resident 1 was found on the floor by staff, and he stated was reaching for his water bottle. 9) Non-injury fall on 06/22/2023 Resident 1 pushed their tray table away. 10) Non-injury fall on 05/24/2023. Resident 1 was reaching for water bottle. 11) Non-injury fall on 05/25/2023 Resident 1 was trying to change position and sit at the edge of the bed but missed and slid down. 12) On 06/03/2023 Resident 1 had three non-injury falls from their bed reaching for their water, trying to get their remote which was on their bed and trying to sit at the edge of their bed to watch TV. 13) Non-injury fall on 06/14/2023. Resident 1 self-transferred. 14) Non-injury falls on 06/16/2023, 06/18/2023, 06/20/2023, 06/22/2023, 06/26/2023 and 06/28/2023.

Review of Negotiated Care Plan (NCP) with various dates showed that the AFH had interventions such as encourage Resident 1 to use their call light, educated for safety use of call light, seen by PT, snacks available within their reach, talked to staff not to leave them on their commode, beddings changed to cotton, safety checks every 30 minutes for one month, water bottle brought closer to table, educated to call for help, personal belongings within reach, room move closer to living room and regular bed changed to [redacted]. NCP showed that the interventions of visual checks were documented four times. The NCP throughout Resident's 1 fall did not meet resident's needs that lead to 21 falls.

In an interview on 07/12/2023 at 3:02 PM, Resident 1 stated that they thought they could still do what they used to do. Resident 1 stated that they thought they could transfer and walk on their own, but their legs were weak, and they could not flatten their feet on the floor.

During a telephone interview on 10/05/2023 at 3:11 PM, Staff A, Provider, stated that they could not afford one-on-one care for Resident 1. Staff A stated that they thought they did everything to keep Resident 1 safe.

Attestation Statement

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Attestation Statement

Statement of Deficiencies	License #: 755744	Compliance Determination # 26560
Plan of Correction	Hannah's Serene AFH LLC	Completion Date
Page 4 of 4	Licensee: Hannah's Serene AFH LLC	10/06/2023

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, Hannah's Serene AFH 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.

Ruth Kihara
Provider (or Representative)

10/13/2023
Date

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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, Hannah's Serene 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

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Plan/Attestation Statement

The last fall for the resident was on 6/28/2023

The mitigating factors put on place

1. Changing the resident Room from Room [redacted] to Room [redacted] next to Living Room helped - Resident within close vicinity and keeping the door open.
2. Having a [redacted] and keeping Residents belonging within reach all the times
3. providing Residents with Snacks as needed.
4. Residents strength is improving.

Ruth Kihara 10/13/2023

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