



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Bridgeport Adult Family Home LLC
BRIDGEPORT ADULT FAMILY HOME LLC
5405 104th St SW
Lakewood, WA 98499

RE: BRIDGEPORT ADULT FAMILY HOME LLC License # 757207

Dear Provider:

This letter addresses Compliance Determination(s) 72076 (Completion Date 01/29/2026) and 68945 (Completion Date 11/20/2025).

The Department completed a follow-up inspection of your Adult Family Home on 01/29/2026 and found that you have corrected the violations listed in the Complaint report dated 11/20/2025. Your home is back in compliance as of 12/04/2025 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 388-76-10220-2, WAC 388-76-10225-1-b-iii

The Department staff who did the on-site verification:
Lisa Charette, NCI AFH Complaint Investigator

If you have any questions, please contact me at (253)208-3090.

Sincerely,

Rathana Duong, AFH Field Manager
Region 3, Unit A
Residential Care Services

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



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 757207	Compliance Determination # 68945
Plan of Correction	BRIDGEPORT ADULT FAMILY HOME LLC	Completion Date
Page 1 of 4	Licensee: Bridgeport Adult Family Home LLC	11/20/2025

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 11/19/2025 of:

BRIDGEPORT ADULT FAMILY HOME LLC
5405 104th St SW
Lakewood, WA 98499

This document references the following complaint number(s): 200293

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 investigated the Adult Family Home:

Lisa Charette, NCI AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit A
PO Box 99250
Lakewood, WA 98496

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

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.

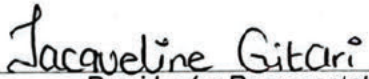


Residential Care Services

11/26/2025

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)

12/4/25

Date

WAC 388-76-10220 Incident log. The adult family home must keep a log of:

(2) Accidents or incidents affecting a resident's welfare; and

This requirement was not met as evidenced by:

Based on interviews and record review, the Adult Family Home (AFH) failed to keep a log of resident incidents and accidents for 1 of 5 residents (Resident 2). This failure placed residents at risk of not having accidents and incidents investigated and placed residents at risk of injury and diminished quality of life and prevented the AFH from tracking or trending incidents to identify patterns.

Findings included...

On 11/19/2025 in a record review of the AFH's Incident Log, there were no incidents recorded for any resident.

On 11/19/2025 in a record review of Resident 2's (R2) medical record, an After Visit Summary dated [REDACTED]/2025 - [REDACTED]/2025 showed that R2 had been admitted to the hospital for an involuntary hold after a suicide attempt that took place away from the AFH. Progress notes dated [REDACTED]/2025 showed that R2 returned to the AFH on [REDACTED]/2025.

On 11/19/2025 at 10:53 AM in an interview, Staff A (the Provider) was asked when they knew that R2 had been admitted to the hospital. Staff A said, "Honestly, I didn't find out that R2 was in the hospital until they were being discharged. There was a miscommunication with my staff and they assumed R2 had decided to stay with their parents and did not notify me that R2 had not returned to the AFH on [REDACTED]/2025."

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

Statement of Deficiencies

License #: 757207

Compliance Determination # 68945

Plan of Correction

BRIDGEPORT ADULT FAMILY HOME LLC

Completion Date

Page 3 of 4

Licensee: Bridgeport Adult Family Home LLC

11/20/2025

When asked why R2 being a missing resident was not recorded on the Incident Log, Staff A said that R2 had already returned, and they didn't think about it.

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, BRIDGEPORT ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 12/14/25.

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

Jacqueline Gitari
Provider (or Representative)

12/14/25
Date

WAC 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(b) Report the following to the department by calling the complaint toll-free hotline number or completing an online report:

(iii) A missing resident.

This requirement was not met as evidenced by:

Based on interviews and reviews, the Adult Family Home (AFH) did not report a missing resident to the Department or law enforcement for 1 of 5 residents (Resident 2). This failure placed the residents at risk for injury or harm and diminished quality of life.

Findings included...

On 11/19/2025 in a record review of Resident 2's (R2) medical record, an After Visit Summary from the hospital dated [REDACTED]/2025 - [REDACTED]/2025 showed R2 had been admitted to the hospital.

On 11/19/2025 at 10:53 AM in an interview, Staff A (the Provider) was asked when they knew that R2 had been admitted to the hospital. Staff A said, "Honestly, I didn't find out that R2 was in the hospital until they were being discharged. There was a miscommunication with my staff, and they assumed R2 had decided to stay with their parents and did not notify me that R2 had not returned to the AFH on [REDACTED]/2025." When asked if R2 being a missing resident was reported to Local law enforcement (LLE)

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

Statement of Deficiencies

License #: 757207

Compliance Determination # 68945

Plan of Correction

BRIDGEPORT ADULT FAMILY HOME LLC

Completion Date

Page 4 of 4

Licensee: Bridgeport Adult Family Home LLC

11/20/2025

or the Department, Staff A stated they had not reported the missing resident because R2 was already returning to the AFH when they were notified R2 had been missing from the home.

On 11/19/2025 at 11:13 AM in an interview with R2, they were asked if they had communicated with the staff prior to leaving the AFH on [REDACTED]/2025 about where they were going and when they would be back. R2 said, "I told them I was going to my friend's house and would be back that night."

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, BRIDGEPORT ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 12/4/25.

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

Jacqueline Citari
Provider (or Representative)

12/4/25
Date

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