STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

AFH at Silver Lake, LLC
Kenmore Assisted Senior Home
18539 73rd Ave NE
Kenmore, WA 98028

RE: Kenmore Assisted Senior Home License # 756445

Dear Provider:

This letter addresses Compliance Determination(s) 37513 (Completion Date 02/29/2024) and 33934 (Completion Date 01/09/2024).

The Department completed a follow-up inspection of your Adult Family Home on 02/29/2024 and found that you have corrected the violations listed in the Complaint report dated 01/09/2024. Your home is back in compliance as of 01/22/2024 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 388-76-10655-1, WAC 388-76-10655-2, WAC 388-76-10655-3, WAC 388-76-10680, WAC 388-76-10350-2-a

The Department staff who did the on-site verification:
Ywen Dah Liou, AFH Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit K
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Kenmore Assisted Senior Home
Provider Type: Adult Family Home
License/Cert.#: 756445
Intake ID: 110244
Compliance Determination #: 33934
Region/Unit #: RCS Region 2 / Unit K
Investigator: Ywen Dah Liou
Investigation Date(s): 12/14/2023 through 01/09/2024
Complainant Contact Date(s): 01/04/2024, 12/14/2023, 12/20/2023

Allegation(s):
Named Resident (NR) of the Adult Family Home (AFH) was mechanically restrained.

Investigation Methods:

Sample:	Total residents: 2 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Identified staff Residents Family members Healthcare provider
Record Reviews:	Medical records Facility policies Personnel files Staff training records Face sheet Background checks Assessment Negotiated care plan Progress notes

Investigation Summary:
Interview indicated that NR was mechanically restrained by an identified AFH staff. Record review exhibited that NR had right to be free from physical or chemical restraints. Further record review exhibited that the AFH failed to provide alternative methods prior to the use of unauthorized mechanical restraints. Failed practice identified.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 756445	Compliance Determination # 33934
Plan of Correction	Kenmore Assisted Senior Home	Completion Date
Page 1 of 9	Licensee: AFH at Silver Lake, LLC	01/09/2024

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 12/14/2023 and 12/14/2023 of:

Kenmore Assisted Senior Home
18539 73rd Ave NE
Kenmore, WA 98028

This document references the following complaint number(s): 110244

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

The department staff that investigated the Adult Family Home:

Ywen Dah Liou, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit K
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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.

Ann Lee-Hunter
Residential Care Services

01/22/2024
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 #: 756445	Compliance Determination # 33934
Plan of Correction	Kenmore Assisted Senior Home	Completion Date
Page 2 of 9	Licensee: AFH at Silver Lake, LLC	01/09/2024

MIKI UM
Provider (or Representative)

1/22/2024
Date

WAC 388-76-10655 Physical and mechanical restraints. The adult family home must ensure:

(1) Each resident's right to be free from physical and mechanical restraints used for discipline or convenience;

(2) Prior to the use of physical or mechanical restraints, less restrictive alternatives have been tried and documented in the resident's negotiated care plan;

(3) The physical or mechanical restraints have been assessed as necessary to treat the resident's medical symptoms and addressed on the resident's negotiated care plan; and

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure alternative behavioral interventions were tried before using mechanical restraints on 1 of 2 sampled residents (Resident 1). The AFH also failed to ensure Resident 1 was assessed for the use of restraints and failed to include restraints on the Negotiated Care Plan (NCP). This failure resulted in Resident 1 being mechanically restrained.

Findings included...

Record review of the AFH's policy titled, "Residents Rights Policy," dated 06/29/2023, exhibited that Resident 1 had the right to be free from physical or chemical restraints.

Review of Resident 1's Face Sheet, undated, showed the AFH admitted Resident 1 on [redacted]/2023.

Record review of Resident 1's hospice record, dated on 12/13/2023, exhibited that, on 12/13/2023, during the visit from 10:25 AM to 11:30 AM, Collateral Contact 1 (CC1) Registered Nurse (RN) found Resident 1's hands were tied to both sides of the bed with hand mittens/restraints.

Review of Resident 1's assessment, dated on 06/29/2023, exhibited Resident 1 had a diagnosis of [redacted]. The assessment showed Resident 1 was not oriented to place or time. Cognition showed "ability to make decisions about daily life is poor; requires reminders, cues and supervision

in planning daily routines." Communication showed Resident had impairment in understanding and impairment in expressing self. Mental Health section showed "Resident requires calm and reassuring environment, limit stressors, provide structure." The assessment showed Resident 1 was incontinent of urine, wore pullups, needed assistance to use the toilet and cleaning after.

Further review of Resident 1's records exhibited that the AFH had no assessment for the use hand mittens/restraints to Resident 1.

Record review of Resident 1's NCP dated, 08/02/2023, showed the following: Resident 1 was incontinent of both bowel and bladder urgency/frequency associated with cognitive/neurological decline. Resident wears pull-ups full time. Caregivers to setup bedside commode for use at nighttime. Inappropriate toileting activity, takes off pull-ups in bed, resulting in wetting the bed frequently. The NCP did not have caregiver instructions or interventions for inappropriate toileting. The NCP did not contain any information regarding the use of hand mittens or ties.

During an interview on 12/14/2023 at 9:11 AM, CC1 RN stated that they found Resident 1's hands were tied to both sides of the bed with mittens and ties to their wrists during the visit on 12/13/2023. CC1 stated that the AFH did not notify them regarding the use of hand mittens/restraints and ties to Resident 1. CC1 stated that they were not aware the AFH used hand mittens and ties because of Resident 1's new inappropriate toileting behaviors.

During an interview with Resident 1 on 12/14/2023 at 10:35 AM, they were unable to answer any questions.

During an interview on 12/14/2023 at 10:44 AM, Staff C (Caregiver) stated that she has been working for the AFH for approximately one month. Staff C stated that on the morning of 12/13/2023, she was the only caregiver on duty. Staff C stated that on the morning of 12/13/2023 she did not place hand mittens and ties on Resident 1's hands. Staff C stated that she and Staff B Resident Manager (RM) had been placing mittens and tying the hands of Resident 1 on a daily basis. Staff C stated that she was instructed by the AFH provider to place hand mittens and ties on the hands of Resident 1 whenever the resident was in bed.

Record review of Staff C's undated orientation records exhibited the AFH hired Staff C on 11/08/2023. Further review showed Staff C signed the AFH's Abuse/Neglect policy on 11/11/2023.

During an interview on 12/14/2023 at 11:05 AM, Staff B (Resident Manager) (RM) stated that on the morning of 12/13/2023, she was in the home, but not on shift to work. Staff C requested that she come and speak with the CC1 RN regarding the restraints. Staff B went to Resident 1's room, she found Resident 1's hands were tied to both sides of the bed with hand mittens/restraints. Staff B stated that she did not place the hand mittens or the ties on Resident 1. Staff B stated that she recognized the hand mittens as the same ones that

the AFH provider had brought to the home.

Record review of Staff B's undated orientation records exhibited the AFH hired Staff B on 07/26/2019. Further review showed Staff B signed the AFH's Abuse/Neglect policy on 06/17/2019.

During an interview on 12/14/2023 at 11:32 AM, Collateral Contact 2 (CC2) Resident 1's Durable Power of Attorney (DPOA) stated that, they were not aware of the use of any hand mittens or the ties to Resident 1.

During an interview on 12/14/2023 at 12:27 PM, Staff A (Provider) stated, she did not know Resident 1's hands were tied to both sides of the bed with hand mittens/restraints until the report from Staff B. Staff A stated that she brought the hand mittens/restraints to the AFH around July 2023. Staff A stated that she planned to use the hand mittens/restraints for the prevention of Resident 1's altered behavior, "playing with stool." Staff A stated that, she only instructed AFH staff to apply hand mittens on Resident 1's both hands only, but not ties to the bed. Staff A stated that she did not notify Resident 1's health care provider or family representative of the behavior of "playing with stool" or the use of the hand mittens.

During an interview on 01/09/2023 at 1:20 PM, Staff A stated that she was aware of the use of hand mittens/restraints to the resident required an assessment and the authorization of the resident's representative and designated healthcare provider. Staff A stated that she was aware of the use of hand mittens/restraints without assessment and authorization violated the resident's right to be free from restraints and affected the physical and mental health of the resident.

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, Kenmore Assisted Senior Home is or will be in compliance with this law and / or regulation on (Date) 1/22/24 .

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

MIKI UM — Provider (or Representative)

1/22/24 — Date

WAC 388-76-10680 Staff behavior related to abuse. The adult family home must ensure that staff do not abandon, abuse, neglect, seclude, exploit, or financially exploit any resident.

Statement of Deficiencies	License #: 756445	Compliance Determination # 33934
Plan of Correction	Kenmore Assisted Senior Home	Completion Date
Page 5 of 9	Licensee: AFH at Silver Lake, LLC	01/09/2024

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure 1 of 2 sampled residents (Resident 1) was free from abuse, when the AFH staff placed mittens on the resident's hands and tied their wrists to the bed. This failure resulted in Resident 1's unreasonable confinement, presumed mental anguish, and placed Resident 1 at risk for diminished quality of life.

Findings included...

Per WAC 388-76-10000, "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. (1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. (2) Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult which have the following meanings:
"Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, or prodding.
"Mental abuse" means a willful verbal or nonverbal action that threatens, humiliates, harasses, coerces, intimidates, isolates, unreasonably confines, or punishes a vulnerable adult. Mental abuse may include ridiculing, yelling, or swearing.

Review of the AFH policy titled, "Kenmore Assisted Living Senior Home Policy Prohibiting Abuse, Neglect, and Exploitation, and Employee Reporting and Documentation Requirements" undated, showed Kenmore Assisted Senior Home will not tolerate verbal, physical, mental, or sexual abuse, exploitation or financial exploitation, or involuntary seclusion, of any resident by any staff member, other resident or visitor to the home. Staff members will follow the procedures to comply with mandatory reporting laws, documentation requirements, and this AFH policy.

Review of Resident 1's Face Sheet, undated, showed the AFH admitted Resident 1 on [redacted]/2023.

Review of Resident 1's assessment, dated on 06/29/2023, showed Resident 1 had a diagnosis of [redacted]. The assessment showed Resident 1 was not oriented to place or time. Cognition showed "ability to make decisions about daily life is poor; requires reminders, cues and supervision in planning daily routines." Communication showed Resident had impairment in understanding and impairment in expressing self. Mental Health section showed "Resident requires calm and reassuring environment, limit stressors, provide structure." The assessment showed Resident 1 was incontinent of urine, wore pullups, needed

assistance to use the toilet and cleaning after.

Record review of Resident 1's Negotiated Care Plan (NCP), dated on 08/02/2023, showed the following: Resident 1 was incontinent of both bowel and bladder urgency/frequency associated with cognitive/neurological decline. Resident wears pull-ups full time. Caregivers to setup bedside commode for use at nighttime, however the resident may not use the bedside commode due to incontinence. Inappropriate toileting activity, takes off pull-ups in bed, resulting in wetting the bed frequently. The NCP did not have caregiver instructions or interventions for inappropriate toileting. The NCP showed Resident 1 had cognitive changes/decline, caregivers should offer frequent guidance/redirection.

Record review of Resident 1's hospice records, dated on 12/13/2023, showed, on 12/13/2023, during the visit from 10:25 AM to 11:30 AM, Collateral Contact 1 (CC1) Registered Nurse (RN) found Resident 1's hands were tied to both sides of the bed with hand mittens/restraints. Review of the hospice notes for 12/11/2023, the visit conducted two days before the restraint was discovered showed Resident 1 presented as calm and pleasant. The AFH caregiver reported that Resident 1's mood as improved and tolerated some out of room time in the living room. The hospice note did not show any inappropriate behaviors reported by the AFH caregiver.

During an interview on 12/14/2023 at 9:11 AM, CC1 (RN) stated that they came to the home at approximately, 10:25 AM, and found Resident 1 with mittens on both hands, and the mittened hands were tied to the bed. CC1 stated that Staff C (Caregiver) on duty denied tying Resident 1's hands to the bed. CC1 stated that Staff B (Resident Manager) (RM) also denied tying Resident 1's hands to the bed.

During an interview with Resident 1 on 12/14/2023 at 10:35 AM, they were unable to answer any questions.

During an interview on 12/14/2023 at 10:44 AM, Staff C (Caregiver) stated that she had been working for the AFH for approximately one month. Staff C stated that on the morning of 12/13/2023, she was the only caregiver on duty. Staff C stated that at around 7:00 AM she noticed Resident 1 was awake and had a soiled brief that contained stool. Staff C stated that Resident 1 had spread the stool, using their hands onto the bed and other surrounding surface areas. Staff C stated that she contacted the AFH Provider to report the behavior. Staff C stated that the AFH Provider instructed her to place hand mittens on both hands of Resident 1 and tie the hands to the bed. Staff C stated that she and the Resident Manager had been placing mittens and tying the hands of Resident 1 on a daily basis. Staff C stated that on the morning of 12/13/2023 she did not place hand mittens and ties on Resident 1's hands.

Record review of Staff C's undated orientation records exhibited the AFH hired Staff C on 11/08/2023. Further review showed Staff C signed the AFH's Abuse/Neglect policy on 11/11/2023.

During an interview on 12/14/2023 at 11:05 AM, Staff B (RM) stated that on the morning of 12/13/2023, she was in the home, not on work shift. Staff C requested that she come and speak with the CC1 Hospice RN regarding the restraints. Staff B went to Resident 1's room, she found Resident 1's hands were tied to both sides of the bed with hand mittens/restraints. Staff B stated that she did not place the hand mittens or the ties on Resident 1. Staff B stated that she recognized the hand mittens as the same ones that the AFH provider had brought to the home.

Record review of Staff B's undated orientation records exhibited the AFH hired Staff B on 07/26/2019. Further review showed Staff B signed the AFH's Abuse/Neglect policy on 06/17/2019.

During an interview on 12/14/2023 at 11:32 AM, Collateral Contact 2 (CC2) Resident 1's Durable Power of Attorney (DPOA) stated that, on 12/13/2023, they received a message from CC1 Hospice RN, and she requested they come directly to the AFH. CC2 stated that they arrived at the AFH around 10:45 AM, and CC1 showed them the hand mittens which were removed from Resident 1's hands. CC2 informed them that Resident 1's hands been tied to the bed, and they had hand mittens on. CC2 stated that Staff B (RM) informed them that the AFH used hand mittens to Resident 1 because Resident 1 was "playing with stool." CC2 stated that Staff B and Staff C (Caregiver) were unable to tell them who placed hand mittens on Resident 1 and tied their hands to the bed.

During an interview on 12/14/2023 at 12:27 PM, Staff A (Provider) stated that she was not in the AFH at the time of the incident on the morning of 12/13/2023. Staff A stated they did not know Resident 1's hands were tied to both sides of the bed with hand mittens/restraints until the report from Staff B (RM). Staff A stated that she brought the hand mittens to the AFH around July 2023. Staff A stated that they planned to use the hand mittens for Resident 1 due to continued altered behavior, "playing with stool", but she did not instruct the staff to tie Resident 1's hands. Staff A stated that she did not notify Resident 1's health care provider or family representative of the behavior of "playing with stool" or the use of the hand mittens.

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, Kenmore Assisted Senior Home is or will be in compliance with this law and / or regulation on (Date) 1/22/24 .

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

MH UM
Provider (or Representative)

1/22/24
Date

Statement of Deficiencies	License #: 756445	Compliance Determination # 33934
Plan of Correction	Kenmore Assisted Senior Home	Completion Date
Page 8 of 9	Licensee: AFH at Silver Lake, LLC	01/09/2024

WAC 388-76-10350 Assessment Updates required.

(2) The adult family home must ensure each resident's assessment is reviewed and updated to document the resident's ongoing needs and preferences as follows:

(a) When there is a significant change in the resident's physical or mental condition;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to update the assessment for 1 of 2 sampled residents (Resident 1) when they had a change in health condition related to hospice. This failure placed Residents 1 at risk for unmet care needs.

Findings included...

Record review of Resident 1's undated face sheet, exhibited that Resident 1 admitted to the AFH on [redacted]/2023.

Review of Resident 1's assessment, dated on 06/29/2023, exhibited Resident 1 had a diagnosis of [redacted] and [redacted] that caregiver to anticipate needs. Resident 1's assessment did not show any information regarding hospice services.

Record review of Resident 1's Negotiated Care Plan (NCP), dated on 08/02/2023, showed no information regarding hospice services.

Record review of Resident 1's hospice record, dated on 12/13/2023, showed Resident 1 was on hospice care since 08/28/2023.

During an interview on 12/26/2023 at 2:50 PM, Staff A (Provider) stated that they did not updated Resident 1's assessment after Resident 1 was placed on hospice care on 08/28/2023.

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, Kenmore Assisted Senior Home is or will be in compliance with this law and / or regulation on (Date) 1/22/24.

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

Statement of Deficiencies	License #: 756445	Compliance Determination # 33934
Plan of Correction	Kenmore Assisted Senior Home	Completion Date
Page 9 of 9	Licensee: AFH at Silver Lake, LLC	01/09/2024

Michi UM	1/22/24
Provider (or Representative)	Date