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

Everyday Grace Adult Family Home LLC

Everyday Grace Adult Family Home LLC
32737 35th Ave SW
Federal Way, WA 98023

RE: Everyday Grace Adult Family Home LLC License # 756921

Dear Provider:

This letter addresses Compliance Determination(s) 59813 (Completion Date 05/22/2025) and 52176 (Completion Date 03/20/2025).

The Department completed a follow-up inspection of your Adult Family Home on 05/22/2025 and found that you have corrected the violations listed in the Complaint report dated 03/20/2025. Your home is back in compliance as of 04/25/2025 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 388-76-10025-1, WAC 388-76-10025-2, WAC 388-76-10025-3, WAC 388-76-10670-2, WAC 388-76-10670-3, WAC 388-76-10670-4, WAC 388-76-10161-2-a, WAC 388-76-10673-1-a, WAC 388-76-10673-2-a, WAC 388-76-10673-2-b, WAC 388-76-10673-2, WAC 388-76-10561, WAC 388-76-10561-1, WAC 388-76-10561-2, WAC 388-76-10561-2-a, WAC 388-76-10561-2-b, WAC 388-76-10561-2-c, WAC 388-76-10561-2-d, 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

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 12/23/2024, 03/20/2025, 03/21/2025 and 02/24/2025 of:

Everyday Grace Adult Family Home LLC
32737 35th Ave SW
Federal Way, WA 98023

This document references the following complaint number(s): 158628, 167237, 166169, 165410

The following sample was selected for review during the unannounced on-site visit: 5 of 5 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 — 3-21-2025 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) — Date

WAC 388-76-10025 License annual fee.

(1) The adult family home must pay the license fee that is established in the state's operating budget, as described in RCW 70.128.060 .

(2) Each year, the home's annual license fee is due during the same month in which the home was initially licensed. For example, if the home was licensed in June, 2010, then the annual licensing fee will be due in June of each year.

(3) The home must ensure that the department receives the annual license fee when it is due.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to pay the annual license fee due on 12/15/2024. This failure placed five residents (Resident 1, 2, 3, 4, and 5) at risk of possible unmet care needs due to unknown financial status of the AFH.

Findings included...

Observation on 02/24/2025 at 2:00 PM, showed five residents were in the AFH.

Record review of the Department's record on 02/24/2025 at 11:39 AM, showed the AFH did not pay the annual license fee of $1350.00, which was due on 12/15/2024 and remained unpaid when the Department arrived at the AFH.

Record review of the Department Business Operations and Analysis Unit (Oversee financial process of Residential Care Services) email correspondence sent to

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

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Findings included…

Observation on 02/24/2025 at 2:00 PM, showed five residents were in the AFH.

Record review of the Department's record on 02/24/2025 at 11:39 AM, showed the AFH did not pay the annual license fee of $1350.00, which was due on 12/15/2024 and remained unpaid when the Department arrived at the AFH.

Record review of the Department Business Operations and Analysis Unit (Oversee financial process of Residential Care Services) email correspondence sent to

Department Staff (DS) on 02/25/2025 at 9:06 AM, showed that the check Staff A, Provider, sent to the Department was returned to the bank due to insufficient funds in the account.

In an interview on 02/24/2025 at 12:59 PM, Staff A said that they paid the annual license fee in January 2025. Staff A said that they sent a check to the Department but did not get a notification that it had not been processed.

Record review of Staff A's email correspondence to DS on 02/25/2025 at 2:26 PM, showed Staff A had no idea that the check they issued to the Department was returned because of insufficient funds. The email correspondence showed Staff A thought they had received a notification that the payment had been processed and cleared by their bank.

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, Everyday Grace 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

WAC 388-76-10670 Prevention of abuse. The adult family home must:

(2) Ensure each resident's right to be free from abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion;

(3) Protect each resident who is an alleged victim of abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion; and

(4) Prevent future potential abandonment, verbal, sexual, physical and mental abuse, exploitation, financial exploitation, neglect, and involuntary seclusion from occurring.

This requirement was not met as evidenced by:

Based on the interview and record review, the adult family home (AFH) failed to ensure that 1 of 5 residents (Resident 1, Former Resident) was free, protected, and prevented abuse and neglect by two former staff (Staff B, Former Caregiver and Staff C, Former Caregiver) who had no background check on their hire date and allegedly abused them. The AFH failed to investigate Resident 1's reported falls and a fracture of unknown origin. This failure also caused Resident 1 harm from physical and mental abuse from Staff B and Staff C, who provided unsupervised care and services to Resident 1.

Findings included…

Record review of the facility's undated policy titled, "ABUSE, NEGLECT AND EXPLOITATION AND MANDATORY REPORTING POLICY," showed that AFH is dedicated to ensuring all residents in the home will be free of physical, emotional, neglectful treatment and financial exploitation. The AFH will take all prompt and necessary actions to protect residents who, by law, are considered vulnerable adults following allegations of abuse, neglect and financial exploitation.

Record review of AFH Medical Emergency Policy procedure dated 04/21/2022, showed if resident was not in hospice, call "Emergency Medical Services [911] immediately" for the following problems: "falls and shows signs of injuries such as increased mental confusion… head and or body injury; any injury requiring medical attention." Emergency policy showed, "Once resident has been cared for or has been taken to the hospital: Fill out an incident form and investigation immediately; Determine the cause, put in place preventative measures. Log the incident on the DSHS log. Placed on the 3-days alert charting to document resident's progress notes until the issue is resolved; Document in the daily prog notes and inform next shift if problem is resolved, continue to document on problem until resolved.

Record review of the AFH undated new employee paperwork titled, "ADULT FAMILY HOME. Orientation for New Staff," signed by Staff B, undated, showed that they were hired on 11/22/2024 and ended their employment on 12/08/2024. Staff B's records showed under the "Administrative forms (must be completed before start of employment) …Background Check completed and requested within 24 hours. Fingerprint Date established. New staff is not left unattended with resident yet until background check is received."

Record review of the AFH undated new employee paperwork titled, "ADULT FAMILY HOME. Orientation for New Staff," signed by Staff C, showed that they were hired on 11/22/2024 and ended their employment on 12/08/2024. Staff C's records showed under the "Administrative forms (must be completed before start of employment) …Background Check completed and requested within 24 hours. Fingerprint Date established. The new staff will not be left unattended with the resident until the background check is received."

Record review of the AFH medical emergency policy procedure dated 04/21/2022,

showed Staff B signed on 11/16/2024 and Staff C signed on 12/10/2024.

Record review of the AFH undated abuse and neglect policy showed Staff B and C signed on 12/10/2024 after they ended their employment on 12/08/2024.

Record review of the AFH electronic Resident 1's notes titled, "Suspect abuse or neglect," dated 12/08/2024 at 11:00 AM, indicated "Resident 1's three resident representatives told Staff A, Provider, that Resident 1 reported to them that Staff B put their hand on Resident 1's face and pushed them backward. Staff B got mad at Resident 1 for getting up so much. Staff B was a big guy who swore a lot, and Resident 1 did not want to argue with them. Resident 1 felt that Staff B did not like them. Resident 1 reported that Staff C lay on the couch, closed their eyes, and did not answer their questions. Staff C got mad and cranky at Resident 1 and took their walker away when they did not want them to get up. Resident 1 told their CCs that they get along with other staff except Staff B and Staff C".

Record review of an email correspondence sent by Staff A to the Department Staff (DS) on 02/18/2025 at 11:50 AM, showed a picture of Resident 1's face with a bruise between their left eye bag and left cheek area.

Record review of Resident 1's certificate of death dated 01/03/2025, showed Resident 1's cause of death on [redacted]/2024 was [redacted] and [redacted]. The certificate of death showed the manner of death was [redacted].

In a telephone interview on 02/12/2025 at 5:05 PM, Collateral Contact 1, CC 1, Resident Representative, said that Resident 1 told them that they did not feel safe, were mistreated, neglected, and getting abused in the home by Staff B and Staff C. CC 1 said that Staff B put their hand on Resident 1's face, pushed them back, and sustained the left eye bruise. CC 1 said that Staff B and C were not nice to Resident 1, making them feel "very anxious.", and did not feel safe in the home with the night caregivers, Staff B and C. CC 1 said that in 09/2024, Resident 1 reported a fall, and they sustained a pelvic fracture. CC 1 said that Resident 1 reported to them that they hit a wall, went down, fell, and got up while Staff B was sleeping on the couch, who was supposed to be watching them. CC 1 said that they received a text message from Staff F, Caregiver, that Resident 1 had an accident, and they sent a picture of Resident 1's "humongous" bruise on their left eye. The AFH told CC 1 that Resident 1 was anxious and restless that night; they fell forward, hit their face into their walker, and sustained a bruise on their left eye. CC 1 said that the left eye bruise on Resident 1 happened when Staff B pushed Resident 1. In [redacted]/2024, Resident 1 was found with a new compression fracture (a break or crack in a vertebrae that causes the bone to collapse) that caused more pain, was prescribed a strong pain medication, referred to hospice (end-of-life care for patients who no longer benefit from curative treatment and who choose to forego curative treatment) and passed away. Resident 1 felt anxious and restless whenever Staff B and C were the caregivers at night. CC 1 informed Staff A of their concerns about Staff B and C, and Staff A fired both after they were told.

In a telephone interview on 02/13/2025 at 10:28 AM, Staff A said that before hiring new staff, they would run their background check.

In a telephone interview on 02/27/2025 at 12:15 PM, Collateral Contact 2, CC 2, Resident's Representative 2, said that Staff B was neglectful; Resident 1 fell on September 2024 at AFH. gotten up on their own, while Staff B was asleep on the couch who was supposed to be watching them, and Resident 1 sustained a pelvic fracture. CC 2 said that Staff B woke up when Resident 1 fell and did not report the fall. CC 2 added that Resident 1 told them on two different occasions and told CC 1 separately the same story of how they fell. CC 2 said that Staff A told them the fracture did not happen in the home. CC 2 said that on 11/2024, they were notified by Staff B that Resident 1 fell forward and hit their face on their walker. CC 2 said that Resident 1 reported they sustained the bruise on their left eye when Staff B put their hand on their face and shoved them back into the chair. CC 2 said that when Resident 1 was hospitalized in [redacted]/2024, the hospital found new compression fractures based on the x-ray (a quick, painless test that captures images of the structures inside the body-particularly the bones) result. CC 2 said that Resident 1 was in excruciating pain due to the new fractures that Staff B inflicted on them. CC 2 said that Staff B contributed to Resident 1's death. CC 2 said that Staff A never admitted that Resident 1 had a fall in the home. CC 2 said they visited Resident 1 every day and knew all the AFH staff. CC 2 said that Staff B started working in the AFH in 08/2024, and Staff C began at the end of September 2024.

The undated AFH orientation for new staff administrative records review showed Staff B and Staff C were both hired on 11/22/2024, and their employment ended on 12/08/2024. Staff B and C's background check records were completed on 12/11/2024. There were no incident reports, and notes were found in Resident 1's records about their falls, pelvic fractures with unknown sources, and condition changes as required per AFH emergency policy.

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, Everyday Grace 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

WAC 388-76-10161 Background checks Who is required to have.

(2) The adult family home must ensure that all caregivers, entity representatives, and resident managers who are employed directly or by contract after January 7, 2012, have the following background checks:

(a) A Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the adult family home (AFH) failed to ensure valid Washington state name and date of birth background checks (BGC) were completed for 2 of 4 staff (Staff B, Former Caregiver, Staff C, Former Caregiver). This placed residents at risk of harm from staff with unknown background check results.

Findings included…

On 12/23/2024 at 10:33 AM, observation showed five residents (Resident 2, 3, 4, 5 and 6) and one Staff (Staff D, Caregiver) were in the home.

Review of the Department Provider's Letter, dated 11/15/2025, showed that as of 11/01/2024, the Washington State Administrative Office of the Courts (AOC) experienced an outage, which had prevented the Background Check Central Unit ([BCCU] uses a centralized database to conduct background checks) from accessing certain data they normally use to process background checks. Effective 11/15/2024 the DSHS leadership had authorized BCCU to modify the background check system to allow BCCU to proceed with processing background checks without the data from AOC. The Dear Provider letter showed that Providers could submit staff's BGC and Fingerprint background checks, per the normal process.

Review of AFH medical emergency policy dated 04/21/2022, showed Staff B signed on

11/16/2024, before their hire date.

Review of staff records, “ADULT FAMILY HOME. Orientation for New Staff,” showed that Staff B was hired on 11/22/2024 and ended their employment on 12/08/2024. Staff B's BGC was done on 12/11/2024, three days later after the hired date.

Review of staff records, “ADULT FAMILY HOME. Orientation for New Staff,” showed that Staff C was hired on 11/22/2024 and ended their employment on 12/08/2024. Staff C's BGC was done on 12/11/2024, three days later after the hired date.

Review of BCCU Department staff email correspondence to Department Staff on 02/26/2025 at 6:18 PM showed that on 11/18/2024 the background check system was back online and fully functioning.

In a telephone interview on 02/18/2025 at 11:18 AM, Staff A, Provider, said that Staff B and Staff C's background check were delayed because the Washington State Administration AOC was down.

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, Everyday Grace 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

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 interview, observation, and record review, the Adult Family Home (AFH) failed to ensure the allegations of abuse, neglect and mistreatment for 1 of 6 residents (Resident 1, Former Resident) were reported to the Department Complaint Resolution Unit (CRU [Department hotline]) and law enforcement (LE). This failure resulted in the delayed investigation of an allegations of abuse and neglect which caused serious harm to Resident 1 who had a fracture (a partial or complete break in a bone) with unknown origin that required hospitalization. This failure also placed all the residents in the AFH risk of abuse and neglect.

Findings included…

Record review of the AFH's undated abuse policy titled, "ABUSE, NEGLECT AND EXPLOITATION AND MANDATORY REPORTING POLICY", showed that all AFH staff are Mandatory Reporters of potential, real, or suspected resident abuse or neglect. The abuse policy showed staff are required to report to CRU toll free the following: All alleged incidents/events involving abandonment, abuse, exploitation, financial exploitation, and neglect or mistreatment, including injuries of unknown source; "Substantial injuries of unknown source" (not related to suspected abuse or neglect). Abuse policy showed staff are required to report to law enforcement one of the following: When there is a reason to suspect an incident is physical assault, or there is reasonable cause to believe that an act has caused fear of imminent harm.

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.

"Neglect" means:(1) A pattern of conduct or inaction by a person or entity with a duty of

care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or(2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

Review of Resident 1's records showed, Negotiated Care Plan (NCP) dated 07/30/2024 showed AFH admitted [redacted] on [redacted]/2024.

Record review of the AFH's employee records, undated, showed that Staff B, Former Caregiver, began employment on 11/22/2024. AFH's undated titled "ADULT FAMILY HOME. Orientation for New Staff" showed Staff B signed the undated policy.

Record review of the AFH's employee records dated 11/16/2024, showed that Staff C, Former Caregiver, began employment on 11/22/2024. AFH's undated titled "ADULT FAMILY HOME. Orientation for New Staff" showed Staff B signed the policy.

Review of [redacted] medical record dated 09/04/2024 Resident 1 had diagnoses of [redacted], [redacted], [redacted], or [redacted]. Medical Records showed Resident 1 was given the diagnosis of [redacted] in May 2024.

Review of AFH electronic notes dated 12/08/2024 at 11:00 AM, titled "Suspect abuse or neglect," showed that Staff A, Provider, met with Collateral Contact 1, CC 1, Resident Representative 1, Collateral Contact 2, CC2, Resident Representative 2, and Collateral Contact 3, CC3, Resident Representative 3, and they reported, "Staff C lays on the couch, closes their eyes, and doesn't answer Resident 1's questions…Staff C got mad… Staff C's cranky with Resident 1 and takes their walker when Staff C doesn't want Resident 1 to get up. Resident 1 gets along with all the caregivers except Staff B and C."

In a telephone interview on 02/12/2025 at 5:05 PM, CC 1, said that Resident 1 told them they did not feel safe, mistreated and getting abused in the home by Staff B and Staff C. CC 1 said that In September 2024 Resident 1 fell while Staff B, who was supposed to watched Resident 1, was asleep and Resident sustained pelvic fracture. In November 2024, Resident 1 had a bruise under their left eye. Resident 1 said that Staff B pushed them and sustained a bruise on their left eye. In [redacted] 2024, the hospital doctor found four new compression fractures on Resident 1 that caused Resident 1 more pain, hospital gave them heavy pain medication and later passed away. CC 1 said that Resident 1 could tell them who among the caregivers treated them well in the home. CC 1 said that Staff B and C abused Resident 1. Resident 1 said that they did not feel safe with Staff B and C and made restless and felt "very anxious." CC1 said that they reported the incidents to Staff A and Staff A fired both Staff B and C.

In a telephone interview on 02/18/2025 at 11:18 AM, Staff A said that on 12/08/2024, they reported to [redacted] when CC 1, CC 2 and CC 3 told them their concerns about Staff B and C. Staff A said that they reported Staff B and C to the [redacted] messaging system and left a message with staff names. Staff said that they were not aware that they needed to report to Department CRU.

Review of the Department's record showed that the AFH did not report Staff B and C's alleged abuse of Resident 1 to the Department CRU.

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, Everyday Grace 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

WAC 388-76-10561 Resident rights Resident security deposit account.

(1) Funds in excess of one hundred dollars that are paid to an adult family home as a security deposit or as prepayment for charges beyond the first month's residency must be deposited by the adult family home in an interest bearing account that is separate from any of the home's operating accounts and that credits all interest earned on the resident's funds to that account.

(2) The adult family home must:

(a) Provide a record of the account when requested by the resident, the resident's representative, or the department;

(b) Ensure the resident's funds are not mixed with the home's funds or with the funds of any person other than another resident. If an account pools resident funds, there must be a separate accounting for each resident's share;

(c) Ensure that the account(s) are held, and remain until a resident refund occurs, in a financial institution as defined in RCW 30A.22.040 ; and

(d) Notify the resident in writing of the name, address, and location of the depository.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure 1 of 1 Resident (Resident 1, Former Resident) security deposit funds were deposited in an interest-bearing account separate from the AFH's operating funds This failure resulted in a delay in returning the security deposit to Resident 1's Collateral Contact 2 ([CC 2], Resident Representative 2) after Resident 1 passed away.

Findings included…

Record review of Resident 1's Disclosure of charges dated 07/17/2025 showed a Security deposit amount of $8500.

Record review of CC 2's email correspondence on 02/24/2025 at 9:08 PM showed NS did not have separate interest-bearing for Resident 1's security deposit account. CC 2 email correspondence showed Staff A, Provider, did not refund them the security deposit within 30 days of Resident 1's discharge from the AFH.

Record review of CC 2's email correspondence on 02/28/2025 at 7:32 PM showed Resident 1 was admitted to the hospital on [redacted]/2024 and passed away on [redacted]/2024.

Record review of CC 2's bank statement dated 01/24/2025 showed Staff A's, Provider, check to CC 2 was returned unpaid because there were no sufficient funds.

In an interview on 02/24/2025 at noon, CC 2 said that Staff A did not refund them the security deposit within the 30-day window and still owed them money.

In an interview on 02/25/2025 at 5:07 PM, Staff A said that they did not have a separate interest-bearing account for Resident 1's security deposit. Staff A said that they were unaware they had to have separate accounts for Residents' funds.

Refer to WAC 388-76-10540 Resident rights—Disclosure of charges—Notice requirements—Deposits.

(6) The adult family home must provide the resident with any and all refunds due within thirty days from the resident's date of discharge from the home.

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, Everyday Grace 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

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:

(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 observation, interview, and record review, the adult family home (AFH) failed to review and update 2 of 2 residents (Resident 1, Former Resident, and Resident 4)

Negotiated Care Plan (NCP) to address their multiple diagnoses, behaviors and fall incidents. This failure caused Resident 1 decrease quality of life and unmet care needs. This also placed Resident 4 at risk of not receiving the care and services to meet their needs.

Findings included…

<Resident 1>
Record review of Resident 1's doctor notes dated 07/16/2024, showed the following diagnoses; [redacted].

Record review of Resident 1's NCP dated 07/30/2024, showed they were admitted to the home on [redacted]/2024. Staff A, Provider, signed and dated the NCP on 12/04/2024, and Collateral Contact 1, CC 1, Resident Representative 1, signed the NCP undated. NCP did not addressed the interventions for [redacted] medical diagnoses.

Records review of Resident 1's electronic records showed that from 07/19/2024 to [redacted]/2024, the following behaviors were not addressed in the NCP: struggle adapting to new environment, confusion, agitation, insomnia, restlessness, and disruption of other residents' sleep. Electronic notes showed Resident 1 was constantly wanting to walk, crying because of pain; Resident 1 reported incidents of falls, alleged abuse and neglect. Resident 1's documented multiple behavior were not updated in Resident 1's NCP.

Additional record review of Resident 1's assessment dated 09/11/2024, showed their NCP was not updated for the following: dizziness/vertigo, physical/mental function fluctuation, daily pain that limited their activity and affected their sleep and increased behavior/acting out. Assessment showed that Resident 1 was on psychotropic medications to help with their sleep.

In addition, a records review of Resident 1's notes showed the following incidents not addressed in the NCP:
-09/01/2024 at 3:42 PM, Resident 1 got up from the white chair in the living room and injured their elbow.
- 09/13/2024, Diagnosis of [redacted].
-10 /27/2024, Resident 1's documented left and right wrist skin tear.

-11/24/2024 at 7:22 AM, two falls.
-11/30/2024 around 3:10 AM, Resident 1 hit themselves with their walker's break and sustained a bruise under their eye.
-12/08/2024, at 7:45 PM, Resident 1 fell into their walker.

In an interview on 02/25/2025 at 4:50 PM, Staff A said that they did a lot for Resident 1's pain and admitted that they did not update Resident 1's NCP.

<Resident 4>
Observation showed that on 02/24/2025 at 1:33 PM, Staff A assisted Resident 4 in getting up from the recliner chair. Observation showed Resident 4 walking from the recliner chair to the kitchen with one person standing by to assist.

Record review of Resident 4's Assessment and NCP, dated 03/06/2024, signed and dated on 03/16/2024 by Resident 4's Representative. On page 54, under fall risk and management, NCP showed that Resident 4 had no recent falls, stable gait, and balance. NCP showed Resident 4 had no sleep disturbances and was on medication for sleep disturbance; NCP indicated that Resident 4 had no nighttime behaviors, mood swings, or falls. NCP showed Resident 4 had no screaming or yelling behaviors

Record review of Resident 4's incident report dated 6/19/2024 showed that they had fallen during the night trying to get up to go to the bathroom, and Resident 4 was sent to the hospital via 911. Resident 4's incident report revealed an injury from the fall but did not indicate what type of injury they had, and moderate pain was identified. Resident 4's incident report showed that the preventative measure implemented was blank, and the negotiated service agreement update was not marked as yes or no.

In an interview on 02/24/2025 at 1:06 PM, Resident 3 said that they saw Resident 4 had a fall in the bathroom less than a week ago. Resident 3 said that someone else helped Resident 4 to get up and could not remember who they were.

In an interview on 02/24/2025 at 1:28 PM, Staff D, Caregiver, said Resident 4 did not have a recent fall. Staff D replied that Resident 4 "badly" screams whenever they have showers. Staff D said that maybe the residents thought Resident 4 fell when they screamed. Resident 4's screaming with showers was not indicated in their NCP.

In an interview on 02/24/2025 at 5:08 PM, Staff A said that Resident 4 had a fall in the home more than six months ago and broke their ankle.

In an interview on 02/25/2025 at 4:50 PM, Staff A said that Resident 4 was difficult at night; a few days ago, they started Resident 4 on medication for their behavior. Staff A

said they reviewed Resident 1's assessment and NCP, which did not match. Staff A said they have a Registered Nurse who updates residents' care plans in the home. Staff A acknowledged that Resident 1 and Resident 4's assessment and care plan were not updated to reflect residents' care needs.

In an interview on 02/25/2025 at 5:25 PM, Resident 2 said they saw Resident 4 slide down the floor from the chair and Staff F pick them up back to the chair. Resident 2 said that they saw Resident 4 did not like taking their pills; they punched, swore, screamed like they were getting killed, and yelled at the staff. Resident 2 said Resident 4 told the staff they would kill them. Resident 2 said Resident 4 was up and down at night, screaming and driving Resident 2 crazy.

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, Everyday Grace 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