STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

Siboj Comfort Care LLC
siboj comfort care llc
15013 NE 91st St
Vancouver, WA 98682

RE: siboj comfort care llc License # 757876

Dear Provider:

This letter addresses Compliance Determination(s) 80464 (Completion Date 07/14/2026) and 76101 (Completion Date 06/25/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/14/2026 and found that you have corrected the violations listed in the Complaint report dated 06/25/2026. Your home is back in compliance as of 06/11/2026 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

The Department staff who did the on-site verification:
Priscilla Changa, Nursing Home Complaint Investigator

If you have any questions, please contact me at (360)664-8421.

Sincerely,

Jennifer LeMaster

Jennifer LeMaster, Community Nurse Field Manager
Region 3, Unit F
Residential Care Services

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

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING ADMINISTRATION

800 NE 136th Ave, Suite 200, Vancouver, WA 98684

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 04/20/2026 and 06/11/2026 of:

siboj comfort care llc
15013 NE 91st St
Vancouver, WA 98682

This document references the following complaint number(s): 212729

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:

Priscilla Changa, Nursing Home Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

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.

Jennifer LeMaster
Residential Care Services

07/01/2026
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.

Mariama Jammeh
Provider (or Representative)

07/2/2026
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;

This requirement was not met as evidenced by:

Based on interview and record review the adult family failed to ensure residents were free from restraints when they blocked emergency exit door to prevent elopement with a [redacted] for 1 of 1 sampled resident (Resident 1) reviewed for restraints. This failure placed all residents at risk for harm.

Findings included...

An announced onsite visit was conducted on 06/11/2026 at 12:44 PM.

Observation on 06/11/2026 at 12:44 PM showed staff pushing the [redacted] away while opening the backyard entrance door. The alarm chimed once when the door was opened. An "emergency exit" sign was observed posted inside the door.

Record review of Resident 1's (R1) medical record showed R1 was admitted to the home on [redacted]/2026 with multiple diagnoses including [redacted] and [redacted].

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

Review of R1's Assessment dated 01/06/2026, documented R1 was impulsive, had a one-on-one (1:1) sitter and did not recognize their limitations. The record documented R1 had a significant traumatic brain injury resulting in impaired cognitive skills in decision making. The record documented R1 had short- and long-term memory problems. The record showed R1 was unsteady and at risk of falls.

Review of R1's Negotiated Care Plan, dated 05/10/2026, documented R1 had pacing, wandering, and exit seeking behaviors. The record documented R1 was unaware of safety concerns and was not to be left alone. The record showed R1 relaxed when they saw a [redacted] at the door.

Record review of an incident report, dated 01/31/2026, documented staff were unable to locate R1 in the home and they notified the provider at 7:00 PM. The provider called law enforcement when they were unable to locate R1 in the neighborhood. The record documented the police called the provider at 5: 00 AM when they located R1. The record documented preventions measures were implemented including placing "extra equipment by the door."

During an interview on 06/11/2026 at 12:47 PM, Staff B, Caregiver stated that R1 had exit seeking behaviors prior to the incident. Staff B stated that it was around 7:00 PM on 01/31/2026 when they completed a head count and realized R1 was not in the home. Staff B indicated that R1 left the home while they provided care to another resident. Staff B stated that they were the only caregiver in the home and was not aware R1 had left the home.Staff B stated that R1 was brought back by the police at around 3:00 AM. Staff B stated that there were alarms on the exit door in backyard and the door into the garage. Staff B stated that the alarms chimed once, sometimes twice and stopped when the doors were open. Staff B said they did not recall if they had heard the alarm go off on 01/31/2026. Staff B stated that they placed the [redacted] in front of the emergency exit door with locked wheels to prevent R1 from leaving home. Staff B stated that R1 still attempts to leave, however, when R1 sees the [redacted] at the door they would not attempt to leave. During onsite visit on 06/11/2026, the Caregiver illustrated how they placed the [redacted] and locked the wheels, blocking the emergency exit door.

During an interview on 06/11/2026 at 1:00 PM, Staff A, Provider, stated that R1 had 1:1 sitter prior to admission to the home and they were aware R1 had exit seeking behaviors. The Provider stated that R1 left the home without staff knowledge. The Provider stated that R1 left property at around 7:00 PM and was brought back by police at 4:00 AM on 01/31/2026. The Provider stated the alarm system on the doors chimed once or twice depending on the settings when the door opened. The Provider said they placed the [redacted] by the emergency exit door to prevent R1 from leaving the home. The Provider stated that R1 knew how to turn off the alarm, and that was the reason why they had [redacted] placed at the door because R1 could not move the [redacted]. The Provider indicated it was not ideal to place a [redacted] at the door/emergency exit door. The Provider stated that the [redacted] was placed there for R1 not to remove it. The Provider said they were aware the intervention was a form of restraint and that the action affected all residents in the home.

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

During an interview on 06/11/2026 at 1:29 PM, R1 stated that they left the home to find where the highway was located. R1 stated that it was a long walk, they were gone for hours and their legs got tired. R1 stated that they were lost and did not know how to get back home. R1 stated that they could not open door since [redacted] was always placed in the front of the door, blocking the way out. R1 stated that they felt "trapped."

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, siboj comfort care llc is or will be in compliance with this law and / or regulation on (Date) 06/11/2026 .

I took out the equipment while the DSHS representative was present at 1:05pm

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

Mariama Jammeh — Provider (or Representative)

07/2/2026 — Date

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