



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

April 13, 2016

Dorothy W Waweru Schlimme  
DOROTHYS ANGEL HAVEN  
1615 4TH ST NE  
AUBURN, WA 98002

RE: DOROTHYS ANGEL HAVEN License #71203

Dear Provider:

On April 12, 2016 the Department completed a review of communication and / or documents from you indicating that you have corrected the deficiency or deficiencies cited in the report/s dated February 29, 2016.

Based on the review of this information the Department finds the deficiency or deficiencies have been corrected. Your home meets the adult family home licensing requirements.

The Department staff who did the off-site verification:  
Julie Miranda, AFH Licenser

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

Sincerely,

Delores Usea, Field Manager  
Region 2, Unit G  
Residential Care Services



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|                           |                          |                   |
|---------------------------|--------------------------|-------------------|
| Statement of Deficiencies | License #: 71203         | Completion Date   |
| Plan of Correction        | DOROTHYS ANGEL HAVEN     | February 29, 2016 |
| Page 1 of 3               | Licensee: DOROTHY WAWERU |                   |

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

The department has completed data collection for the unannounced on-site full inspection of:  
 2/25/2016

DOROTHYS ANGEL HAVEN  
 1615 4TH ST NE  
 AUBURN, WA 98002

The department staff that inspected the adult family home:  
 Julie Miranda, BSN, RN, AFH Licensors

From:  
 DSHS, Aging and Long-Term Support Administration  
 Residential Care Services, Region 2, Unit G  
 20425 72nd Avenue S, Suite 400  
 Kent, WA 98032-2388  
 (253)234-6007

As a result of the on-site full inspection 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.

*Delores V. Seck*

Residential Care Services

*3-2-2016*

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.

*W. Schlimmer*

Provider (or Representative)

*3-10-16*

Date

RECEIVED  
 APR 03 2016  
 DSHS/ADSA/RCS

**WAC 388-76-10360 Negotiated care plan Timing of development Required. The adult family home must ensure the negotiated care plan is developed and completed within thirty days of the resident's admission.**

**This requirement was not met as evidenced by:**

Based on observations, interview and record reviews, the adult family home (AFH) failed to develop a negotiated care plan (NCP) for 1 of 5 residents (Resident #5) within thirty days of the resident's admission to the AFH. This placed the resident at risk for unmet care and services.

Findings include:

Observations, interviews and record reviews occurred on 2/25/2016.

Observed Caregivers B and C providing care to Resident #5 throughout the inspection. On interview, the resident said the staff assisted her with all her care.

Review of records revealed Resident #5 was admitted on [REDACTED] 15. No NCP was found developed for the resident within thirty days of admission to the AFH.

Further review showed a NCP was developed dated 9/29/2015, [REDACTED] months from the resident's initial admission to the AFH. On interview with the Provider, she said a new care plan was not necessary since she used and negotiated the resident's care with the daughter from a previous care plan where the resident resided before dated 5/12/2015, and there were no changes with the resident's care.

**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, DOROTHYS ANGEL HAVEN 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 cited deficiency.

*As of date of visit we had care plans am not sure how the department wants me to correct this*  
*3-10-16*  
 Provider (or Representative) \_\_\_\_\_ Date \_\_\_\_\_  
*if you need me to rewrite the entire care plan please let me know*

**WAC 388-112-0106 Who is required to obtain certification as a home care aide, and when? Unless exempt under WAC 246-980-070 , the following individuals must be certified by the department of health as a home care aide within the required timeframes:**

- (1) All long-term care workers, within one hundred and fifty days of hire;

**This requirement was not met as evidenced by:**

Based on interview and record review, the adult family home (AFH) failed to ensure one of eight caregivers (Caregiver C) was certified as a Home Care Aide (HCA) within the required time frame. This failure placed five residents (Resident #1, #2, #3, #4 and #5) at risk for harm from being cared for by an unqualified caregiver.

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APR 05 2016  
DSHS/ADSAR/RS

Findings include:

Interview and record review occurred on 02/25/2016.

Observed Caregiver C providing care to Resident #1, #2, #3, #4 and #5 throughout the inspection.

Record review of Caregiver C's personnel record revealed he was hired at the AFH on 8/3/2015. Further review revealed he completed a Nursing Assistant Training Program with the Department of Health dated 8/2/2015. No Home Care Aide certification was found since 207 days from hire date.

On interview with the Provider, she said Caregiver C had not taken the examination for the certification since he was hired on 8/3/2015 due to scheduling with the Department of Health.

The regulation stated, unless exempt from being a home care aide, all long-term workers must be certified as a Home Care Aide within one hundred fifty days of hire, and effective 07/28/2013 must be certified by the department of health as a HCA within 200 days of hire.

Caregiver C had been employed in the AFH for 207 days and he was not certified as HCA, as required by law.

**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, DOROTHYS ANGEL HAVEN is or will be in compliance with this law and / or regulation on (Date) 2-25-16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency. *See attached documentation*

*[Handwritten Signature]*

Provider (or Representative)

2-25-16

Date

RECEIVED  
APR 05 2016  
DSHS/ADSA/RCS  
APR 0 2016  
DSHS/ADSA/RCS