



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98907, Lakewood, WA 98496

January 25, 2016

A Grace Joy AFH II LLC
A Grace Joy AFH II LLC
7721.91st Ave SW
Lakewood, WA 98498

RE: A Grace Joy AFH II LLC License #752532

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on January 21, 2016 for the deficiency or deficiencies cited in the report/s dated August 24, 2015 and found no deficiencies.

The Department staff who did the inspection:
Emily Vincent, Complaint Investigator

If you have any questions please, contact me at (253) 983-3826.

Sincerely,

Lisa Cramer, Field Manager
Region 3, Unit A
Residential Care Services



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 PO Box 98907, Lakewood, WA 98496

RECEIVED
 SEP 02 2015
 DSHS RCS Region 3

Statement of Deficiencies	License #: 752532	Completion Date
Plan of Correction	A Grace Joy AFH II LLC	August 24, 2015
Page 1 of 3	Licensee: A Grace Joy AFH II LLC	

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 complaint investigation of: 7/6/2015
 A Grace Joy AFH II LLC
 7721 91st Ave SW
 Lakewood, WA 98498

This document references the following complaint numbers: 3118558 , 3117734
 The department staff that inspected and investigated the adult family home:
 Emily Vincent, BSN, RN, Complaint Investigator

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

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.

L. Cramer
 Residential Care Services

8/24/15
 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.

J. Stinson
 Provider (or Representative)

8/27/15
 Date

8/27/15
10/23

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 and record review, the adult family home (AFH) failed to report an incident of physical abuse to the department and local law enforcement when one of six current residents (R1) reported she had been hit in the face by another resident (R2). This failure resulted in ongoing fear for R1 and placed other residents in the AFH at risk of harm from abuse that had not been identified, reported and investigated. Findings include:

Interviews and record reviews were conducted between 7/6/15 and 8/24/15, unless otherwise noted.

AFH progress note dated 6/17/15 revealed R1 complained to the Resident Manager (RM) that she had been hit in the face by R2. The RM was busy preparing food at the time and did not see R2 hit R1, but said she had seen R1 get out of her dining room chair and go over to R2 (who was seated in a recliner in the dining room) and confront him. At that time, R2 hit R1 in the face and R1 told the RM immediately. The RM said she comforted R1 and told her not to go near R2 because he could be verbally abusive, combative and resistive.

According to her current negotiated care plan (NCP), R1 was a [REDACTED] year-old female with diagnoses of major [REDACTED]. R1 had lived in the AFH since [REDACTED] 2014. The NCP noted R1 was easily irritated and agitated by the noise of other residents. Caregivers were to be aware of R1's [REDACTED] give her time alone to think and talk to her about her concerns. If R1 became agitated, caregivers were to talk to her in a calm voice and explain things to her.

Review of R2's 4/20/15 NCP revealed R2 was a [REDACTED] year-old male with a primary diagnosis of [REDACTED]. R2 had moved into the AFH in [REDACTED] 2015. According to the NCP, R1 was resistive to most care, used foul language, yelled and screamed. R2 sat in a recliner in the dining room and repeated [REDACTED] or nonsensical stories aloud. Caregivers were to be aware of R2's behavior especially when he was using foul language and approach him calmly and not argue. If R2 was agitated, caregivers were to leave R2 alone for a while and re-approach him later.

Interview with R1 revealed R2 would curse, yell and be loud and this made R1 angry. "I get very scared" because it (R2's behavior) reminded her of her "family life, which was very difficult." R1 revealed an extensive history of abuse during the interview. With regard to the current incident, R1 said she came into the dining room and R2 was seated in his recliner. R1 said R2 started yelling at her and calling her names. R2 told R1 she was "mean" and told her to "go away." R1 said she went over to talk to R2 and asked him "What did I do? I just got here!"

At that point, R2 hit R1 in her lower right jaw. R1 said the Entity Representative (ER) and RM were in the kitchen making dinner at the time, so she told them. The ER and RM asked R2 about the incident and he said he "didn't do it." R1 said the ER and RM told her not to go near him again and the ER said, "You should have known better than to go over and try to talk to him." R1 said she was very afraid of going near R2 because she was afraid of doing the wrong thing. R1 said she kept her distance from R2 by staying in her room or going on the patio. R1 also revealed the RM had encouraged her to turn up her TV, go for a walk or try to block out the noise from R2.

Interview with the RM revealed she had not witnessed R2 hitting R1, but R1 had made her aware of it at the time. The RM said R2 punched caregivers all the time and it didn't hurt much and she did not believe R1 had been injured as there had not been any complaints of physical discomfort, marks or bruises noted at the time. The RM believed R1's feelings were hurt more than anything because R1 told her it was the "first time a man hit me."

The RM said she had not reported the incident to the department because she was not aware she was required to report abuse between residents and thought only staff abuse of residents had to be reported.

The AFH failed to identify the incident as physical abuse and as a result, the abuse was not reported to the required entities to be investigated.

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, A Grace Joy AFH II LLC is or will be in compliance with this law and / or regulation on (Date) 8/27/2015. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Alvino
Provider (or Representative)

8/27/2015
Date