



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

02/28/2025

Tsigereda Russom Teklu
Flower View Adult Family Home
6620 200th St SW
Lynnwood, WA 98036

RE: Flower View Adult Family Home # 753134

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55611 (Completion Date 02/28/2025) and 52539 (Completion Date 01/29/2025).

The Department completed a follow-up inspection of your Adult Family Home on 02/28/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

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.

WAC 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation or abandonment of a resident:

(i) As required by chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number; and

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

WAC 388-76-10650 Medical devices.

(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

- (a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;
- (b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;
- (c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

WAC 388-76-10165 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161 ;

(2) A national fingerprint background check is valid for an indefinite period of time. The adult family home must ensure there is a valid national fingerprint background check for individuals hired after January 7, 2012 as caregivers, entity representatives or resident managers. To be considered valid, the individual must have completed the national fingerprint background check through the background check central unit after January 7, 2012.

WAC 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

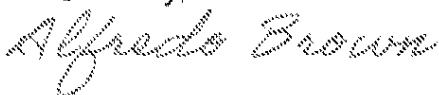
(4) Criminal history disclosure and background check results as required.

The Department staff who did the On Site verification:

Spomenka Hodzic, NCI

If you have any questions, please contact me at (253)341-7376.

Sincerely,



Alfredo Brown, Allied Health Field Manager
Region 2, Unit I
Residential Care Services



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

Statement of Deficiencies	License #: 753134	Compliance Determination # 52539
Plan of Correction	Flower View Adult Family Home	Completion Date
Page 1 of 11	Licensee: Tsigereda Russom Teklu	01/29/2025

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 01/03/2025 of:

Flower View Adult Family Home
6416 180th St SW
Lynnwood , WA 98037

This document references the following complaint number(s): 161414, 161458, 161568, 161668, 163484

The following sample was selected for review during the unannounced on-site visit: 3 of 4 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Renee Bourque, Field Manager
Spomenka Hodzic, NCI

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

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.

Renee Bourque
Residential Care Services

02/07/2025
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 388-76-10680 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.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Adult Family Home (AFH) failed to ensure staff did not abuse 1 of 5 Residents (Resident 5, former resident) when they used mechanical restraints for convenience. This failure resulted in Resident 5 being restrained, contributed to Resident 5's physical and mental harm, and placed 4 of 4 residents currently living in the AFH (Residents 1,2, 3 and 4) at risk of harm from future potential abuse and unmet care needs.

Findings included...

<Abuse>

RCW 74.34.020 Definitions.

(2) "Abuse" means the intentional, willful, or reckless action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. 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. 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: (e) "Improper use of restraint" means the inappropriate use of chemical, physical, or mechanical restraints for convenience or discipline or in a manner that: (i) Is inconsistent with federal or state

licensing or certification requirements for facilities, hospitals, or programs authorized under chapter 71A.12 RCW; (ii) is not medically authorized; or (iii) otherwise constitutes abuse under this section.

Observation, on 01/03/2025 at 11:15 AM, showed the Adult Family Home (AFH) was providing various care and services for four residents.

Review of Resident 5's negotiated care plan (NCP), dated 09/03/2024, showed Resident 5 was admitted to AFH on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED].

Review of Resident 5's assessment, dated 08/24/2024, showed that Resident 5 was receiving weekly support from mental health clinician. Resident 5 had behavioral plan of care to assist AFH in managing their behaviors. Also, Resident 5 had as needed behavioral management support from the mental health clinician.

Record review of AFH's written "Incident Report", dated 01/02/2025, written by medical provider, showed that Resident 5's medical provider found Resident 5 with their both hands [REDACTED] to the [REDACTED] and that medical provider called local law enforcement and an ambulance.

Review of an image (picture) provided by the local enforcement showed Resident 5 lying in the [REDACTED] on their back. Both hands had pink colored [REDACTED] on and at the wrist each hand was [REDACTED] to the [REDACTED] with black colored cloth. Image showed that Resident 5 had some bloody discharge below and around their nostrils. Resident 5's left nostril appeared to be swollen and have more bloody discharge than the right one.

Review of Resident 5's hospital records, dated 01/02/2025, showed Resident 5 was previously hospitalized on [REDACTED]/2024 through [REDACTED]/2024 with left subacute tibial plateau fracture (a partially healed break in shin bone). Additionally, hospital record review showed that during physical examination of Resident 5, on 01/02/2025, Resident 5 had sores inside of their nostrils that had scabbed over. Resident 5 also had an immobilization cast to their left leg, from the mid-thigh to their foot due to broken shin bone.

Record review of AFH's written "Incident Report", dated 01/02/2025, written by Staff H, former caregiver, showed Staff H put [REDACTED] on Resident 5's hands and then [REDACTED] Resident 5's hands to the [REDACTED] because they (Staff H) needed to do laundry and Resident 5 was picking at their nose and making it bleed.

In an interview, on 01/09/2025 at 11:15 AM, Staff A, Provider, stated that on 01/02/2025, they received a phone call from Resident 5's medical provider reporting

that they found Resident 5 [REDACTED] to their [REDACTED]. Staff A stated that at the time of incident they were out of State due to family emergency. Staff A stated that they called Staff G, caregiver and their family member, and asked them to go to the AFH due to an incident with Resident 5. Staff A stated that they instructed Staff G to immediately fire Staff H. Staff A stated that they did not speak to Staff H since the incident because they were angry with Staff H.

In an interview, on 01/09/2025 at 2:57 PM, Staff H stated that they did [REDACTED] Resident 5 to the [REDACTED] [REDACTED] to prevent them from picking their nose. Staff H stated that they were alone with Resident 5 and could not watch over them while doing laundry. Staff H stated that they believed that they could do this because they saw it done in the hospital.

Review of law enforcement officer's body camera recording, recorded on 01/02/2025, showed Staff H was reporting to the police officer that they did [REDACTED] Resident 5's hands because they needed to do laundry, and they were alone in the AFH. Staff H stated on the video recording that this was the first time they [REDACTED] Resident 5's hands, and that Resident 5's hands were [REDACTED] only for about five minutes before the medical provider came to the AFH.

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, Flower View Adult Family Home 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 388-76-10225 Reporting requirement.

(1) The adult family home must ensure all staff:

(a) Report suspected abuse, neglect, exploitation or abandonment of a resident:

(i) As required by chapter 74.34 RCW;

(ii) To the department by calling the complaint toll-free hotline number; and

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(a) The resident's family;

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

This requirement was not met as evidenced by:

Based on observation, interview and record review Adult Family Home (AFH) failed to ensure they notified resident's legal representative when 1 of 5 Residents (Resident 5, former resident) had experienced abuse due to mechanical restraints being applied by Staff H (former caregiver). In addition, AFH failed to notify the Department's centralized reporting unit (CRU) when 1 of 5 residents (Resident 1) reported missing money. This failure resulted in delayed investigation to address potential financial exploitation, and delay in required notification of parties involved in care of the residents.

Findings included...

Observation, on 01/03/2025 at 11:15 AM, showed that Adult Family Home (AFH) was providing various care and services for four residents.

< Resident 5 >

Review of Resident 5's negotiated care plan (NCP), dated 09/03/2024, showed that Resident 5 was admitted to AFH on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED].

Record review of AFH's written "Incident Report", dated 01/02/2025, showed Resident 5's medical provider found Resident 5 in bed, with their hands [REDACTED] to their [REDACTED].

In an interview, on 01/09/2025 at 11:15 AM, Staff A, Provider, stated that they did not notify or speak to Resident 5 legal representative about the incident because they were embarrassed by the whole situation.

< Resident 1 >

Review of Resident 1's negotiated care plan (NCP), dated 05/11/2024, showed that Resident 1 was admitted to AFH on [REDACTED]/2023 with multiple medical diagnosis including [REDACTED].

In an interview, on 01/03/2025 at 1:10 AM, Resident 1 reported that they were missing twenty dollars from their wallet. They stated that they did not report this to any of the AFH staff members at that time. In additional interview, on 01/09/2025 at 11:05 AM, Resident 1 stated that they were still missing twenty dollars, and they told Staff F, housekeeper, about it.

In an interview, on 01/09/2025 at 11:45 AM, Staff F, stated that Resident 1 never told them about missing money or anything else. Staff F stated that if they did report it to them, they would have reported to Staff A.

In an interview, on 01/09/2025 at 11:15 AM, Staff A stated that Resident 1 told Staff B, the administrative personnel, last week, they were missing \$5000 dollars. Staff A stated that they knew that Resident 1 did not have this kind of money and therefore they did not make any reporting to the Department. Staff A stated that they would make reporting to the CRU.

In an interview, on 1/17/2025 at 12:51 PM, Collateral Contact 1 (CC1), stated that about year ago they withdrew \$ 2500 dollars from Resident 1's account and placed it in their purse in the envelope. Shortly the envelope disappeared from Resident 1's purse. CC1 stated that they left voice mail and texted Staff A about the issue, but they have not heard back from Staff A.

Review of Department's Safety, Tracking And Reporting System (STARS) showed that AFH did not make a report on either of the incidents with Resident 1.

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, Flower View Adult Family Home 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 388-76-10650 Medical devices.

(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;

(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed

decision about whether to use the device;

(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

This requirement was not met as evidenced by:

Based on observation, interview and record review the Adult Family Home (AFH) failed to ensure they had assessment identifying need and resident's ability to safely use [REDACTED] for 1 of 5 Residents (Resident 5, former resident). In addition, AFH failed to ensure Resident 5's legal representative was able to make informed decision about use of [REDACTED], and Resident 5's negotiated care plan indicated use of the [REDACTED]. This failure placed Resident 5 at risk for mechanical restraint, and possible injury and death.

Findings included...

Observation, on 01/03/2025 at 11:15 AM, showed a [REDACTED] in Resident 5's room. The [REDACTED] was observed to have full set of [REDACTED] (two [REDACTED] on each side, totaling four half [REDACTED] on the bed).

Review of law enforcement officer's body camera recording, recorded on 01/02/2025, showed Resident 5 in the [REDACTED] laying on their back with four half- [REDACTED] raised up.

Review of Resident 5's negotiated care plan (NCP), dated 09/03/2024, showed Resident 5 was admitted to AFH on [REDACTED]/2023 with multiple medical diagnoses including [REDACTED]. Further review of Resident 5's NCP showed the AFH failed to add use of [REDACTED] for Resident 5.

Review of Resident 5's hospital records, dated 01/02/2025, showed Resident 5 was previously hospitalized on [REDACTED]/2024 through [REDACTED]/2024 with left subacute tibial plateau fracture (a partially healed break in shin bone). Additionally, hospital record review showed that during physical examination of Resident 5, on 01/02/2025, Resident 5 had sores inside of their nostrils that had scabbed over. Resident 5 also had an immobilizing cast to their left leg, from the mid-thigh to their foot due to broken shin bone.

In an interview, on 01/09/2025 at 2:57 PM, Staff H, former caregiver, stated that they moved the [REDACTED] from an unoccupied room to Resident 5's room with Staff D, caregiver, because Resident 5 needed a [REDACTED] to help with their mobility. Staff H

stated that Resident 5 needed a [REDACTED]. Staff H stated that the [REDACTED] came with four half-[REDACTED] already attached to the bed. Staff H stated that they did [REDACTED] Resident 5 to the [REDACTED] to prevent them from picking their nose. Staff H stated that they were alone with Resident 5 and could not watch over them while doing laundry. Staff H stated that they believed that they could do this because they saw it done in the hospital.

In an interview, on 01/09/2025 at 11:15 AM, Staff A, Provider, stated when they left AFH, for their trip out of State, Resident 5 was sleeping on two low height mattresses as they negotiated with Resident 5's legal representative and for Resident 5's safety. Staff A stated that they told Staff H that Resident 5 cannot have a [REDACTED] with [REDACTED] because they did not have doctors' orders and paperwork done.

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, Flower View Adult Family Home 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 388-76-10165 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The adult family home must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for each individual listed in WAC 388-76-10161 ;

(2) A national fingerprint background check is valid for an indefinite period of time. The adult family home must ensure there is a valid national fingerprint background check for individuals hired after January 7, 2012 as caregivers, entity representatives or resident managers. To be considered valid, the individual must have completed the national fingerprint background check through the background check central unit after January 7, 2012.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Adult Family Home (AFH) failed to ensure that 1 of 8 Staff members (Staff F, housekeeper) had a Washington state name and date of birth background check and 1 of 8 Staff members (Staff H, former caregiver) had national fingerprint background check. This failure resulted in 4 of 4 Residents (Resident 1,2,3, and 4) being cared for by a staff members with unknown background history.

Findings included...

Observation, on 01/03/2025 at 11:15 AM, showed that the Adult Family Home (AFH) was providing various care and services for four residents.

<Staff H>

Record review of Staff H's "Orientation Documentation" showed Staff H was hired by the AFH on 08/18/2022 and terminated on 01/02/2025.

Record review of Staff H's personnel records showed the AFH did not have national fingerprint background check record for Staff H.

In an interview, on 01/09/2025 at 11:15 AM, Staff A, Provider, stated that Staff H had national fingerprint check, but they could not find it. Staff A stated that they believe that Staff H took their national fingerprint record with them on the day when they got terminated.

<Staff F>

Record review of Staff F's Washington state name and date of birth background check showed that it had been completed on 10/11/2022.

Review of Staff F's background check showed it had expired on 10/11/2024 and that AFH was eighty-four days overdue in completing new background check for Staff F.

In an interview, on 01/09/2025 at 11:15 AM, Staff A, Provider, stated that they would do Washington state name and date of birth background check for Staff F immediately.

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, Flower View Adult Family Home 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 388-76-10198 Adult family home Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(4) Criminal history disclosure and background check results as required.

This requirement was not met as evidenced by:

Based on observation, interviews and record review Adult Family Home (AFH) failed to have personnel records for 3 of 8 Staff members (Staff A, Provider, Staff D and E, Caregivers) readily accessible for Department's review. This failure placed Residents 1, 2, 3, and 4 at risk of being cared for by Staff members who were not fully qualified.

Findings included...

Observation, on 01/03/2025 at 11:15 AM, showed the Adult Family Home (AFH) was providing various care and services for four residents.

Review of Staff A's and Staff E's personnel records, on 01/03/2025 showed the AFH did not have records for Staff A's and Staff E's national fingerprint background check.

Review of Staff D's personnel records, on 01/03/2025, showed the AFH did not have records for Staff D's Washington state name and date of birth background check.

In an interview, on 01/03/2025 at 11:47 AM, Staff B, administrative personnel, stated that Staff A had personnel records, they just could not find the records.

Record review of personnel’s records on subsequent on site-visit, on 01/09/2025, showed the AFH had Staff A’s and Staff E’s national fingerprint background check and Staff D’s Washington state name and date of birth background check.

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, Flower View Adult Family Home 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