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

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

RE: Flower View Adult Family Home License # 753134

Dear Provider:

This letter addresses Compliance Determination(s) 63826 (Completion Date 08/11/2025) and 59403 (Completion Date 06/12/2025).

The Department completed a follow-up inspection of your Adult Family Home on 08/11/2025 and found that you have corrected the violations listed in the Complaint report dated 06/12/2025. Your home is back in compliance as of 06/23/2025 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 388-76-10225-1-a-ii, WAC 388-76-10225-2-d, WAC 388-76-10400-2, WAC 388-76-10400-3-a

The Department staff who did the on-site verification:
Nylay Quist, AFH Complaint Investigator

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Renee' Bourque

Renee Bourque, Field Manager
Region 2, Unit I
Residential Care Services

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

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 # 59403
Plan of Correction	Flower View Adult Family Home	Completion Date
Page 1 of 6	Licensee: Tsigereda Russom Teklu	06/12/2025

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 05/12/2025 of:

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

This document references the following complaint number(s): 177134, 176474, 178426, 177102

The following sample was selected for review during the unannounced on-site visit: 3 of 6 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Nylay Quist, AFH Complaint Investigator

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.

Statement of Deficiencies	License #: 753134	Compliance Determination # 59403
Plan of Correction	Flower View Adult Family Home	Completion Date
Page 2 of 6	Licensee: Tsigereda Russom Teklu	06/12/2025

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' Bourgue — Residential Care Services

06/16/2025 — 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)

6/23/2025 — 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:

(ii) To the department by calling the complaint toll-free hotline number or completing an online report; 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:

(d) Other appropriate professionals working with the resident;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Adult Family Home (AFH) failed to notify the Complaint Resolution Unit (CRU) when 1 of 6 residents (Resident 1) had an unwitnessed fall with injury in the AFH. This failure resulted in Resident 1 sustaining multiple ribs and spinal bones fractured and placed Resident 1 at risk not getting proper medical treatment and unmet care needs.

Findings Included...

Review of the AFH fall protocol policy, undated, showed the AFH Staff are required to notify "relevant personal according to established protocols. Notify DSHS injury line".

Review of Resident 1's record showed Resident 1 was admitted to the AFH on [redacted]/2024 with multiple diagnoses that included [redacted], [redacted], and [redacted].

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

[redacted]).

Record review of the AFH incident log, dated [redacted]/2025, show Resident 1 had a fall on [redacted]/2025. Resident 1 complained of pain in both shoulders. The Incident log further showed the Emergency Medical Service (EMS) responded and wanted to take Resident 1 to the hospital on [redacted]/2025, but Resident 1's Representative had refused EMS transport of Resident 1 to the hospital.

Record review of the EMS report, dated [redacted]/2025 showed the EMS staff had responded to Resident 1's fall incident on [redacted]/2025. The record showed EMS staff discussed and recommended further evaluation for Resident 1. The report showed Resident 1's Representative had signed a refusal form. The report showed EMS staff recommended a call back if there were any changes.

Record review of the Secure Tracking and Reporting System (STARS), on 05/09/2025, showed no report placed by any AFH staff about Resident 1's fall incident on [redacted]/2025.

Review of hospital records, dated [redacted]/2025, showed Resident 1 was admitted on [redacted]/2025 to [redacted]/2025 due to multiple ribs fractured.

Review of Resident 1's hospital radiology report, dated [redacted]/2025, showed Resident 1 had "acute (a traumatic injury, a sudden, one-time event) nondisplaced (the bone is cracked or broken, but it stays in its proper anatomical position) or mildly displaced second through fifth ribs fractures" and "acute L1 superior endplate compression fracture" (a type of broken bone where a vertebra in the spine collapses, resulting in a loss of height or a wedge-shaped deformity).

Observation, on 05/12/2025 at 10:12AM, showed Resident 1 sitting in a chair at the dining table eating breakfast. Resident 1 was observed to walk slowly with caregiver's assistance back to their room.

In an interview, on 05/12/2025 at 12:45PM, Resident 1 could not answer any question about their fall incident. Resident 1 could not recall having any fall incidents or any injury.

In an interview, on 05/12/2025 at 12:17PM, CC1 stated that the AFH staff had told them (CC1) Resident 1 had a fall on [redacted]/2025. CC1 stated that Resident 1 had not told them (CC1) that they (Resident 1) had any pain. CC1 stated that they visited Resident 1 at the AFH every day. CC1 stated that sometimes, Resident 1 can tell them (CC1) if they had pain, and sometimes Resident 1 cannot tell them (CC1) if they (Resident 1) had pain. CC1 stated that Resident 1 spent most of their (Resident 1) time in bed for three days after their fall incident on [redacted]/2025. CC1 stated that Resident 1 was sent to the hospital on [redacted]/2025.

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

In an interview, on 05/12/2025 at 11:17AM, Staff B (Resident Manager) stated that Resident 1 had a fall on [redacted]/2025. Staff B stated that they had not witnessed Resident 1's fall on [redacted]/2025. Staff B stated that they heard a "loud thump", and they found Resident 1 lying on their back in the living room walkway. Staff B stated that Resident 1 complained of pain in both shoulders and their stomach area. Staff B stated that they reported the incident to Staff A, Provider, Resident 1's Representative, and 911. Staff B stated that they had not reported Resident 1's fall incident on [redacted]/2025 to the CRU because they forgot. Staff B stated that Resident 1 was sent to the hospital on [redacted]/2025.

In an interview on 05/12/2025 at 10:44AM, Staff A stated that Resident 1 had a fall on [redacted]/2025. Staff A stated that no one had witnessed Resident 1's fall on [redacted]/2025. Staff A stated that Staff B found Resident 1 sitting on the floor next to their bed in their room. Staff A stated that Resident 1 told Staff B that they (Resident 1) did not have any pain. Staff A stated that they called 911 and reported Resident 1's fall incident on [redacted]/2025 to Resident 1's Representative, family, and Doctor. Staff A stated that they did not report Resident 1's fall incident on [redacted]/2025 to the CRU because there were no injuries to Resident 1. Staff A stated that Resident 1 was sent to the hospital on [redacted]/2025.

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) 6/23/2025

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

Provider (or Representative) — Date: 6/23/2025

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

This requirement was not met as evidenced by:

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

Statement of Deficiencies	License #: 753134	Compliance Determination # 59403
Plan of Correction	Flower View Adult Family Home	Completion Date
Page 5 of 6	Licensee: Tsigereda Russom Teklu	06/12/2025

Based on interviews and record review, the Adult Family Home (AFH) staff failed to ensure that 1 of 5 residents (Resident 5) reached the highest level of wellbeing and improve quality of life by not attending the required monthly [redacted] ([redacted]) meeting with Resident 5's [redacted] care team for the past ten months. This failure placed Resident 5 at risk for unmet care needs.

Findings Included...

Review of Resident 5's record showed Resident 5 was admitted to the AFH on [redacted]/2021 with multiple diagnoses that included [redacted] ([redacted]), [redacted] ([redacted]), and [redacted] ([redacted]).

Review of the Secure Tracking and Reporting System (STARS) on 05/09/2025 at 07:18AM showed the AFH had a current [redacted] contract until 07/31/2028.

Reviewed of the [redacted] contract signed by Staff A, Provider, on 08/16/2020, showed the AFH staff "Work with DSHS and the DSHS contracted [redacted] Provider to Coordinate and schedule [redacted] team meetings at least once a month for each [redacted] resident". The [redacted] contract further showed the AFH was to "Ensure that a staff of the AFH participate are in each of the [redacted] team meeting".

Reviewed of Resident 5's assessment, dated 08/24/2024, showed Resident 5 was on an [redacted] program.

In an interview, on 05/08/2025 at 7:51AM, CC2 stated that someone from the AFH staff were supposed to attend the monthly [redacted] meeting for Resident 5. CC2 stated that no AFH staff had attend the [redacted] team meeting on behalf of Resident 5 that were held on 7/18/2024, 8/14/2024, 9/11/2024, 10/9/2024, 11/13/2025, 12/11/2024, 1/8/2025, 2/12/2025, 3/12/2025, and 4/9/2025. CC2 stated that Staff A, Provider, was notified via email invitations and many times by phone calls.

In an interview, on 05/12/2025 at 10:30AM, Resident 5 stated that they did not know if someone was supposed to attend the [redacted] meeting for them or not.

In an interview, on 05/12/2025 at 10:44AM, Staff A stated that they are aware of the monthly [redacted] meeting. Staff A stated that they used to attend the monthly [redacted] meeting for Resident 5 before. Staff A stated that they had not seen any meeting notice or invitation from the Resident 5's [redacted] team member since Resident 5 had a new Case Worker. Staff A stated that they had only talked with a [redacted] that came and visited Resident 5 every 2 weeks.

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

In an interview, on 05/27/2025 at 11:36AM, CC3 stated that Resident 5 was in the [redacted] program for at least one and a half years. CC3 stated that Resident 5's SBS care team continued to hold their monthly meeting. CC3 stated a reminder email invitation was sent on a reoccurrence interval to Staff A, but Staff A chose not to attend the monthly [redacted] meeting about Resident 5. CC3 stated that someone from the AFH staff is supposed to attend the monthly [redacted] meeting for Resident 5.

In an interview, on 06/03/2025 at 4:48PM, Staff A stated that they had not attended the monthly [redacted] meeting for Resident 5 for many months. Staff A stated that a Social Worker was responsible to set up the monthly [redacted] meeting and send a meeting link to all the [redacted] tam members. Staff A stated that they had asked the [redacted] about the meeting, but did not receive any answer. Staff A stated that they never got any notification, invitation, or received any link to the monthly [redacted] meeting for Resident 5. Staff A stated that they had not reached out to the [redacted] care team to inquire about the monthly [redacted] meeting for Resident 5.

Review of an email screen shot send to Department Staff, on 05/27/2025 at 12:06PM showed Staff A was included in a meeting noticed that was sent on 03/10/2025. The meeting notice included a link to the monthly [redacted] meeting to discuss about Resident 5.

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) 6/23/2025

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

Provider (or Representative) — Date 6/23/2025

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

Correction for citation: June 2025

FLOWER VIEW AFH

1) WAC 388-76-10225 – Reporting requirements

This will be corrected. This AFH will ensure that any type of serious injury, trauma, or death of a resident will be reported to the health care provider, and other appropriate professionals working w/the resident. This AFH will not assume that a caregiver reported, I as a provider will do the reporting.

2) WAC 388-76-10400 - Care and services

This has been corrected and will be attending monthly [redacted] meetings from now on. This AFH will continue to follow up with the [redacted] social worker and [redacted] support for the resident to ensure proper care for the resident will always be met.

[redacted] 6/23/2025

Provider Signature Date

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