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

Lourdes Loving Care AFH LLC

Lourdes Loving Care AFH LLC
30442 8th Avenue S
Federal Way, WA 98003

RE: Lourdes Loving Care AFH LLC License # 753737

Dear Provider:

This letter addresses Compliance Determination(s) 44336 (Completion Date 07/24/2024) and 35066 (Completion Date 02/29/2024).

The Department completed a follow-up inspection of your Adult Family Home on 07/24/2024 and found that you have corrected the violations listed in the Complaint, Full report dated 02/29/2024. Your home is back in compliance as of 04/30/2024 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 388-76-10176-2, WAC 388-76-10415-1, WAC 388-76-10255-1, WAC 388-76-10420-7-b, WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10510-2, WAC 388-76-10650-2-a, WAC 388-76-10650-2-c, WAC 388-76-10675-2, WAC 388-76-10780-1-a, WAC 388-76-10780-1-b, WAC 388-76-10780-2, WAC 388-76-10895-2-b

The Department staff who did the on-site verification:
Marites Gatan, NCI

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

Sincerely,

Lydia Owusu-Acheampong, Field Manager
Region 2, Unit G

Residential Care Services

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

02/29/2024

Lourdes Loving Care AFH LLC
Lourdes Loving Care AFH LLC
30442 8th Avenue S
Federal Way, WA 98003

RE: Lourdes Loving Care AFH LLC # 753737

Dear Provider:

This document references the following complaint numbers 110448, 114276.

The Department completed a full inspection of your Adult Family Home on 02/29/2024 and found that your home does not meet the Adult Family Home Licensing requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect the home to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Dahl Kim, Field Manager
Residential Care Services

Region 2, Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-76-10015 License Adult family home Compliance required.

(1) The licensed adult family home must comply with all the requirements established in chapters 70.128 , 70.129, 74.34 RCW, this chapter and other applicable laws and regulations including chapter 74.39A RCW; and

The Adult Family Home (AFH) failed to follow the required respiratory fit testing [checking whether a respirator (device used to protect a person from inhaling hazardous fume, vapors, gases, dust, or airborne causing disease) properly fits the face of someone who wears it] for 4 of the 6 staff (Staff B, Caregiver, Staff C, Caregiver, Staff D, Caregiver and Staff F, Housekeeper) and one House Hold Member (HH) who worked in the home. This AFH had the 2 of the staff (Staff C and Staff D) and HH completed their respiratory fit testing on 01/17/2024. Staff B and Staff F had left the AFH and no longer worked there.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
• Ask questions and provide written information to help clarify or dispute the deficiencies.

• Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:

• Please contact me at (253)234-6007.

Sincerely,

Dahl Kim

Dahl Kim, Field Manager
Region 2, Unit G
Residential Care Services

Enclosure

Plan
(Plan of Correction)

You Must:
Return the plan, on the enclosed report, within 10 calendar days after you receive this letter.

Include the following in your plan for each deficiency:
- The date you have or will correct each deficiency; and
- Provide a signature and date certifying that you have or will take corrective measures to correct each cited deficiency.

Send your plan to:
Dahl Kim, Field Manager
Residential Care Services
Region 2, Unit G
20425 72nd Avenue S, Suite 400
Kent, WA 98032

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: https://www.dshs.wa.gov/altsa/idr

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Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services

PO Box 45600
Olympia, WA 98504-5600

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20425 72nd Avenue S, Suite 400, Kent, WA 98032

Statement of Deficiencies	License #: 753737	Compliance Determination # 35066
Plan of Correction	Lourdes Loving Care AFH LLC	Completion Date
Page 5 of 22	Licensee: Lourdes Loving Care AFH LLC	02/29/2024

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 the unannounced on-site full inspection and complaint investigation on 01/10/2024 and 01/10/2024 of:
Lourdes Loving Care AFH LLC
30442 8th Avenue S
Federal Way, WA 98003

This document references the following complaint numbers: 110448, 114276.

The following sample was selected for review during the unannounced on-site visit: 4 of 6 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Marites Gatan, NCI

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

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.

Dahl Kim — 02/29/2024

Residential Care Services — 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) 03/11/2024 Date

WAC 388-76-10176 Background checks Employment Provisional hire Pending results of national fingerprint background check. The adult family home may provisionally employ individuals hired after January 7, 2012 and listed in WAC 388-76-10161 for one hundred twenty-days and allow those individuals to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observations, interview and record review, the Adult Family Home (AFH) failed to ensure 1 of 5 current staff (Staff B, Caregiver) hired after 01/07/2012 had the required national fingerprint background check (FBC) 120 days after employment. This failure placed all residents at risk of harm from staff with an unknown fingerprint-based criminal history.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff. Staff B stated that Staff C, Caregiver worked with them, was providing shower care to Resident 2 inside the hallway bathroom.

Observation on 01/10/2024 at 9:55 AM showed Staff C walked Resident 2 with a walker and assisted them to sat down in the chair in the living room area. Staff B had an unsupervised access with the residents while Staff C was with Resident 2.

Observation on 01/10/2024 at 10:06 AM showed Staff B went to Resident 4 's bedroom and gave their morning medication. There was no other AFH staff that went with them to the room.

In an interview on 01/10/2024 at 11:12 PM, Staff A, Entity Representative/Resident Manager stated that Staff B worked full time and lived in the home.

Observation on 01/10/2024 at 11:25 AM showed Staff B fed Resident 3 lunch inside their bedroom. There was no other AFH staff inside the bedroom.

Review of staff records showed that the AFH hired Staff B on 01/05/2023. There was no

record of a FBC for Staff B.

In a telephone conversation on 01/11/2024 at 11:53 AM, Staff A stated that Staff B did not complete a FBC as they were told that the system was unable to read her fingerprints.

On 01/12/2023, Staff A emailed documents dated 03/28/2023, 02/28/2023 and 01/30/203 from Department of Social Health and Services Oversight Program with a title of "Notification of Rejected Fingerprint." The document stated that the requested FBC "cannot be completed by Washington State Patrol. The applicant must be re-fingerprinted."

There was no record that Staff B went for re-fingerprinting.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/04/2024.

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

Lourdes Lovings — Provider (or Representative) — 03/08/2024 — Date

WAC 388-76-10415 Food services. The adult family home must:

(1) Ensure that the safe food handling training requirements of chapter 388-112A WAC are met; and

This requirement was not met as evidenced by:

Based on observations, interviews and record review, the Adult Family Home failed to ensure that that 1 of the 2 sampled staff (Staff B, Caregiver) had the required food training when they prepared food for 4 of 6 current residents (Resident 2, 4, 5, and 6). This failure placed the four residents at risk for food borne illness.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff.

In an interview on 01/10/2024 at 10:17 AM, Staff B stated that they would cook oatmeal for Resident 5's breakfast.

Observation on 01/10/2024 at 10:20 AM, showed Staff B washed hands with soap and water in the kitchen sink. Staff B had their hands wet, dripped of water and used their right elbow to turn off the faucet. Staff B then used the kitchen towel to dry their hands. Department staff informed Staff B to repeat the procedure.

In an interview on 01/10/2024 at 10:21 AM, Staff B had no reply when department staff asked reason that they had to repeat the handwashing procedure.

Observation on 01/10/2024 at 10:22 AM showed Staff B cooked oatmeal in the kitchen for Resident 5.

Observation on 01/10/2024 at 11:46 AM showed Staff B cooked beans for Resident 4 and re-heated clam chowder soup for Resident 2.

Observation on 01/10/2024 at 11:55 AM showed Staff B with bare hands was putting mayonnaise on a slice of bread. Further observation showed a plate with two slices of bread with mayonnaise on it. The sandwich was for Resident 6. Staff B was informed to stop the procedure, to throw away the rest of the bread slices and repeat the procedure.

In an interview on 01/10/2024 at 11:56 AM, Staff B had no response when asked regarding use of gloves when touching ready-to eat-foods.

Review of "Food Safety is Everybody's Business; Your Guide to Preventing Food Borne Illnesses" dated, May 2013 from Washington Department of Health, showed that staff were not allowed to touch ready-to-eat foods with their bare hands, this was to keep germs from getting ready-to-eat foods. It stated that staff must wash their hands at a handwashing sink that has hot and cold running water, soap, and paper towels (or other single use drying method).

Record Review of Amended April 12, 2023, "Dear Adult Family Home Provider" Letter stated that staff who do not have an active food handler's permit must take the .5 Continuing Education hours annually to maintain food handling and safety training. It stated that the training must occur prior to the staff handling food or providing food service in the AFH. The letter further stated that since the licensing inspection had resumed the department had to verify these requirements.

Review of Staff B's personnel records showed hire date of 01/05/2023. Staff B had no record of food safety training or food handler card.

In an interview on 01/10/2024 at 6:17 PM, Staff A, Entity Representative/Resident Manager stated that Staff B's food handler card might be expired.

In a telephone conversation on 01/11/2024 at 11:51 AM, Staff A stated that Staff B did not want to provide their food handler card as they no longer worked at the home.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/04/2024.

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

Provider (or Representative) 03/08/2024 Date

WAC 388-76-10255 Infection control. The adult family home must develop and implement an infection control system that:

(1) Uses nationally recognized infection control standards;

This requirement was not met as evidenced by:

Based on observations and interviews, the Adult Family Home (AFH) failed to ensure that correct handwashing procedure was practiced by 2 of 5 staff (Staff B, Caregiver and Staff C, Caregiver). The AFH failed to ensure that infection control procedure was followed by 1 of 5 staff (Staff C, Caregiver) when they provided care for 1 of 6 residents (Resident 3). In addition, the AFH failed to maintain infection control standard in caring for Resident 5's oxygen tubing. These failures placed all six current residents at risk of acquiring infectious disease.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff. Staff B stated that Staff C worked with them on that day.

On Washington State Department of Social and Health Services Information for Adult Family Home Providers website under "AFH Standard Precaution Table" was a guideline for Hand Hygiene, Resident Care Equipment and Environment, and Staff Education.

Hand washing

Observation on 01/10/2024 at 10:04 AM, showed Staff B washed hands with soap and water in the kitchen sink, rubbed hands for less than 10 seconds, did not dry hands and turned off faucet with the right hand. Department staff informed Staff B to repeat the task.

In an interview on 01/10/2024 at 10:05 AM, Staff B smiled and had no response when department staff asked reason that they needed to repeat the handwashing procedure.

Observation on 01/10/2024 at 10:20 AM, showed Staff B washed hands with soap and water in the kitchen sink. Staff B had their hands wet, dripped of water and used their right elbow to turn off the faucet. Staff B then used the kitchen towel to dry their hands. Department staff informed Staff B to repeat the procedure.

In an interview on 01/10/2024 at 10:21 AM, Staff B had no reply when department staff asked reason that they had to repeat the handwashing procedure.

Observation on 01/10/2024 at 10:42 AM showed Staff C washed their hands with soap and water. Staff C dried their hands with paper towel, using the same paper towel turn off the faucet, was still holding the same paper towel with right hand took new paper towel and dried their hands again.

In an interview on 01/10/2024 at 10:43 AM, Staff C stated they did not realize that they were holding on to the used paper towel while drying hands for the second time.

Observation on 10:48 AM showed Staff B washed their hands with soap and water. Staff B while rubbing hands with soap touched a glass in the sink area, rubbed their hands and touched a jar in the sink area.

In an interview on 10:49 AM Staff B stated they were just checking the items in the sink.

Infection Control

Observation on 01/10/2024 at 9:53 AM showed oxygen tubing connected from an oxygen concentrator (medical device that uses air around to make an oxygen) with the nasal cannula (flexible tube that is placed under the nose) laid on the floor from inside Bedroom D all the way to the TV area.

During environmental tour on 01/10/2024 at 1:01 PM, department staff pointed out to

Staff A, Entity Representative/Resident Manager the oxygen tubing connected from oxygen concentrator with the nasal cannula prong laid on the floor from inside Bedroom D all the way to the TV area. Staff A disconnected the nasal cannula tubing and threw it out on the garbage.

Observation on 01/10/2024 at 3:30 PM showed Staff C removed soiled incontinent briefs and cleaned Resident 3. Staff C still wearing the same gloves was observed in a process of getting new pad for the bed when department staff informed them to stop.

In an interview on 01/10/2024 at 3:33 PM, Staff C stated that they forgot to change their gloves.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/14/2024.

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

Lourdes Jangam
Provider (or Representative)

03/08/2024
Date

WAC 388-76-10420 Meals and snacks. The adult family home must:

(7) Ensure food is:

(b) Safe, sanitary, and uncontaminated.

This requirement was not met as evidenced by:

Based on observations, interviews, and record review the Adult Family Home (AFH) failed to ensure food handling procedures were followed by 2 of 5 staff (Staff B, Caregiver and Staff C, Caregiver) when they prepared meals for 2 of 6 residents (Resident 4 and Resident 6). This failure placed Resident 4 and Resident 6 at risk for food borne illness.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff. Staff B stated that Staff C worked with them on that day.

Observation on 01/10/2024 at 9:42 AM showed Resident 6 in the television area, sat up in their motorized wheelchair and held coffee cup with their hands.

Observation on 01/10/2024 at 9:47 AM showed Resident 4 inside their bedroom, laid in bed, covered with blanket, wore eyeglasses with the television turned on.

Review of "Food Safety is Everybody's Business; Your Guide to Preventing Food Borne Illnesses" dated, May 2013 from Washington Department of Health, showed that staff were not allowed to touch ready-to-eat foods with their bare hands, this was to keep germs from getting ready-to-eat foods. It stated that staff must wash their hands at a handwashing sink that has hot and cold running water, soap, and paper towels (or other single use drying method). It showed that staff are required to wash their hands before they begin food preparation and anytime their hands maybe contaminated. That the times of heaviest contamination included handling garbage.

Staff B

Observation on 01/10/2024 at 11:55 AM showed Staff B with bare hands was putting mayonnaise on a slice of bread. Further observation showed a plate with two slices of bread with mayonnaise on it. Staff B was informed to stop the procedure, to throw away the rest of the bread slices and repeat the procedure.

In an interview on 01/10/2024 at 11:56 AM, Staff B had no response when asked regarding use of gloves when touching ready-to eat-foods.

Staff C

Observation on 01/10/2024 at 10:01 AM, showed Staff C cracked an egg into a bowl, opened the under the sink cabinet and threw the eggshells in the garbage can. Department staff stopped Staff B when they were going to proceed to scramble the egg in the bowl.

In an interview on 01/10/2024 at 10:02 AM, Department staff asked Staff C what should have been done prior to scrambling the egg. Staff C answered that they should have worn gloves. Staff C was informed that they should have washed their hands.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/04/2024

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

Provider (or Representative) Date 03/08/2024

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(c) Medication log is kept current as required in WAC 388-76-10475 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the Adult Family Home failed to have a medication system in place to ensure that the medications in the medication log that they initialed as given daily were current orders and the medication supplies were available for 2 of the 4 sampled residents (Resident 3 and Resident 5). In addition, the AFH failed to ensure that 1of 4 sampled residents (Resident 5) had their as needed (PRN) medications available. These failures placed Resident 3 and Resident 5 at risk of unmet medication needs and a decline in their medical condition.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff.

In an interview on 01/10/2024 at 11:07 AM, Staff A, Entity Representative/Resident Manager stated that Resident 3 and Resident 5 required medication assistance.

Resident 3

Record review of Resident 3's January 2024 pharmacy generated medication log showed the resident was prescribed of Vitamin K (supplement) capsules 1000 micrograms take one capsule by mouth for one dose dated 11/28/2023. The medication log was initialed as given from January 1 to January 9, 2024.

Record review of Resident 3's December 2023 pharmacy generated medication log showed that there was no order for the Vitamin K Capsule.

Observation on 01/10/2024 at 3:00 PM showed that there was no medication supply for Vitamin K.

In an interview on 01/10/2025 at 3:02 PM, Staff A stated that it was their mistake that they initialed the medication log without checking the order.

In a telephone conversation on 02/23/2024 at 4:19 PM, Collateral Contact 4 (CC 4) stated that the Vitamin K medication was delivered on 11/23/2023 and it was an one-time order. CC 4 stated that they did not know the reason that Vitamin K was printed in the January 2024 pharmacy generated medication log. In addition, CC 3 stated that AFH provider should be checking the medication log for accuracy and should not be signing for medication that they were not giving.

Resident 5

Record review of Resident 5's 2024 January pharmacy generated medication log showed resident was prescribed Spiriva (medication that relaxes muscles in the airways and increases air flow to the lungs) inhale one capsule contents in two inhalations via handihaler (egg shaped inhalation device used to inhale the dry powder) device by mouth daily, Loperamide (medication that decreases the frequency of diarrhea) two milligram (mg) take two capsules by mouth every six hours PRN for diarrhea and Melatonin (medication for sleep) 3 mg take one tablet by mouth daily PRN for insomnia.

Record review of Resident 5's December 2023 pharmacy generated medication log showed there was no order for Spiriva.

Observation on 01/10/2024 at 4:00 PM showed resident has no medication supply of Spiriva, Loperamide and Melatonin.

In an interview on 01/10/2024 at 4:02 PM, Staff A stated that it was their mistake that they initialed the Spiriva as given without checking. In addition, Staff A acknowledged that they do not have the medication supplies of Loperamide and Melatonin.

In a telephone conversation on 02/23/2024 at 11:49 AM, Collateral Contact 3 (CC3) stated that the Spiriva medication was discontinued last December 2023. CC 3 stated that Loperamide and Melatonin medications were sent on 12/08/2023 and there was no further delivery. In addition, CC 3 stated that PRN medications were not delivered automatically and had to be requested by the AFH.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/14/2024.

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

Provider (or Representative) 03/08/2024 Date

WAC 388-76-10510 Resident rights Basic rights. The adult family home must ensure that each resident:

(2) Is treated with courtesy, dignity, and respect;

This requirement was not met as evidenced by:

Based on observations and interviews, the Adult Family Home (AFH) staff failed to treat with courtesy and respect 3 of 6 residents (Resident 1, 3 and 5). This failure placed residents at risk of decreased quality of life.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B, Caregiver stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff. Staff B stated that Staff C, Caregiver worked with them on that day.

In an interview on 01/10/2024 at 10:48 AM, Staff A, Entity Representative/Resident Manager stated that Resident 1 and Resident 2 cannot be interviewed.

Observation on 01/10/2024 at 11:52 AM showed that Resident 1 stood up from the chair in the living room area and started to walk. Staff B and Staff C talked in their native language and walked towards Resident 1. Department staff informed caregivers to stop talking in their native language in the presence of resident who did not understand their language.

Observation on 01/10/2024 at 1:03 PM showed Staff B talked in their native language in the living room area with Resident 1 and Resident 2. Department staff informed Staff B that Resident 1 did not understand their language.

Observation on 01/10/2024 at 3:38 PM showed Staff B and Staff C were inside Resident 3's bedroom to provide care and both talked in their native language. Department staff informed them to use English language.

In an interview on 01/10/2024 at 4:32 PM, Resident 5 stated that they felt irritated when the AFH staff talked in their native language around residents.

In an interview on 01/10/2024 at 5:35 PM, Resident 3 stated that it bothered them that the AFH staff talked in their native language "all the time" when they provided care for them.

In an interview on 01/10/2024 at 6:08 PM, Staff A stated that they reminded their AFH staff to refrain from talking in their native language.

In a telephone conversation on 02/07/2024 at 2:37 PM, Collateral Contact (CC 1) stated that they have observed AFH staff talking in their native language when they visited the home.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/14/2024.

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

Provider (or Representative) 03/08/2024 Date

WAC 388-76-10650 Medical devices.

(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;

(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 observations, interviews, and record reviews, the Adult Family Home (AFH) failed to ensure an assessment was completed and use of [redacted] was included on negotiated care plan (NCP) for 1 of 4 sampled residents (Resident 3). This failure placed Resident 3 at risk for injury.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B, Caregiver stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff.

Observation on 01/10/2024 at 9:41 AM showed Resident 3 laid in bed covered with blanket. The bed had two [redacted] on bilateral upper sides.

Record review of Resident 3's 10/27/2023 History Significant Change Assessment indicated "sharp decline on client's health." The assessment indicated resident required total dependence of one-person physical assist for bed mobility. The assessment showed resident equipment's were manual wheelchair and [redacted]. The assessment did not indicate that Resident 3 used [redacted].

Record review of Resident 3's 12/14/2023 NCP showed that they admitted the resident to the AFH on [redacted]/2023. The NCP showed that the resident was totally dependent on one person for bed mobility and transfer tasks. The NCP did not indicate use of [redacted].

In an interview on 01/10/2024 at 12:47 PM, Resident 3 stated that they used the [redacted] in their bed since they were admitted at the home.

In an interview on 01/10/2024 at 3:25 PM, Staff A, Entity Representative/Resident Manager stated that Resident 3 used the [redacted] since admission to the home on [redacted]/2023. Staff A stated they would search their email for Resident 3's [redacted] assessment.

In an interview on 01/10/2024 at 3:27 PM, Staff A stated that they thought the [redacted] was included in Resident 3's NCP.

An email was received on 01/19/2024 from Staff A that contained Resident 3's [redacted] order dated 01/16/2024 written by Occupational Therapist and reviewed and approved by Physician.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 04/14/2024

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

Lourdes Lovings — Provider (or Representative)

03/08/2024 — Date

WAC 388-76-10675 Adult family home rules and policies related to abuse Required. The adult family home must develop and implement written rules and policies that:

(2) Requires staff to report possible abuse, and other related incidents, as required in chapter 74.34 RCW; and

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the Adult Family Home (AFH) failed to ensure that 1 of 2 sampled staff (Staff B) understood the home's rules and policies related to abuse and neglect, and its implementation. This placed 6 of 6 current residents (Residents 1, 2, 3, 4, 5 and 6) at risk for staff not reporting abuse, neglect, or financial exploitation to the pertinent authority.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B, Caregiver stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff.

In an interview on 01/10/2024 at 11:12 PM, Staff A, Entity Representative/Resident Manager stated that Staff B lived in the home.

Record review of Staff B's administrative records showed they were hired on 01/05/2023. The records showed that Staff B had completed their orientation to the home on 01/05/2023.

Record review of the AFH undated "Prevention of Abuse Policy" stated that all AFH staff are

"mandated to report if there are reasonable basis to believe that a resident is or likely to be abused." The policy stated that caregivers must report on their own without need to inform the AFH Provider and it listed the number to call.

Observation on 01/10/2024 at 12:15 PM during environmental tour the AFH had the Complaint Resolution Unit posted at their bulletin board located in the visible location in the common area.

In an interview on 01/10/2024 at 4:40 PM, Staff B stated that when they see or discovered abuse, neglect, or exploitation they would " call or talk to the Provider."

In an interview on 01/10/2024 at 5:48 PM with Staff A present, Staff B stated that when they see or discovered abuse, neglect, or exploitation they would tell the Provider and would "teach the caregiver."

Observation on 01/10/2024 at 5:50 PM showed that Staff A told Staff B to call the hotline when an abuse, neglect or exploitation was seen or discovered.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 03/14/2024.

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

Lourdes Gonzalez — 03/08/2024

Provider (or Representative) — Date

WAC 388-76-10780 Toilets and bathing facilities.

(1) All adult family homes must ensure the home has toilets and bathing facilities that provide each resident with privacy and include at least:

(a) One indoor flush toilet for each five persons including residents and household members in the home; and

(b) Sinks with hot and cold running water.

(2) Homes licensed after July 1, 2007, must also ensure each resident has access to a toilet, and bathing facilities without going through another person's room.

This requirement was not met as evidenced by:

Based on observations and interviews, the Adult Family Home (AFH) failed to ensure that there was enough toilet for current six residents (Residents 1, 2, 3, 4, 5, and 6), and three staff (Staff B, Caregiver, Staff C, Caregiver and Staff F, Housekeeper) that live on site and one household member (Household Member 1). This failure placed all residents at risk of violation of privacy.

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the AFH. Staff B stated that Staff C worked with them on that day.

Record review of the AFH department summary reports showed that the AFH was licensed effective 06/20/2018.

In an interview on 01/10/2024 at 11:12 PM, Staff A, Entity Representative/Resident Manager stated that Staff B, Staff C and Staff F lived at the home. Staff A added that there were three caregivers that worked "all the time."

Observation on 01/10/2024 at 11:23 AM showed Staff A assisted Resident 2 walked with walker and went inside the hallway bathroom.

During environmental tour on 01/10/2024 at 12:36 PM showed a bathroom in the hallway with a toilet and a shower that had a shower chair inside.

During a bedroom tour on 01/10/2024 at 12:48 PM showed Resident 3 occupied the Bedroom [redacted] with a bathroom consisted of a toilet and a shower inside the bedroom.

In an interview on 01/10/2024 at 12:49 PM, Staff A stated that Resident 3 did not use their bedroom toilet and shower. Staff A stated that Resident 3 was incontinent and would use bedside commode. Staff A added that Resident 3 was unable to use the shower in their bedroom as it was for standing only.

In an interview on 01/10/2024 at 1:30 PM, Staff C stated that they would check the hallway bathroom first and if someone was using that bathroom then they would use Resident 3's bathroom.

In an interview on 01/10/2024 at 3:03PM, Staff B stated that if the hallway bathroom was occupied, the caregivers would use Resident 3's bathroom. Staff B added that only the caregivers had used Resident 3's bathroom.

Observation on 01/10/2024 at 3:43 PM showed Resident 5 wheeled self in the hallway and went inside the hallway bathroom.

In an interview on 01/10/2024 at 6:29 PM, Staff A stated that all six residents used the hallway bathroom for shower. Staff A stated that three residents (Residents 1, 2, and 5) used the toilet in hallway bathroom.

In an interview on 01/10/2024 at 6:31 PM, Staff A stated that "What am I going to do?" when informed that there were total of six residents, three caregivers and one household member that used the hallway bathroom.

In a telephone conversation on 02/23/2024 at 4:38 PM, Resident 3 stated that they felt they could not say anything about the staff that used their bathroom inside their bedroom as they do not own the home.

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, Lourdes Loving Care AFH LLC is or will be in compliance with this law and / or regulation on (Date) 04/30/2024.

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

Provider (or Representative) — Date 03/08/2024

WAC 388-76-10895 Emergency evacuation drills Frequency and participation.

(2) The adult family home must conduct:

(b) A full emergency evacuation drill at least once each calendar year, with all residents participating in the drill together and at the same time; and

This requirement was not met as evidenced by:

Based on interviews and record review the Adult Family Home (AFH) failed to conduct a full emergency evacuation drill at least once each calendar year. This failure placed all 6 of 6 residents (Residents 1, 2, 3, 4, 5, and 6) at risk of harm and injury if an emergency evacuation of the AFH occurred.

Statement of Deficiencies	License #: 753737	Compliance Determination # 35066
Plan of Correction	Lourdes Loving Care AFH LLC	Completion Date
Page 22 of 22	Licensee: Lourdes Loving Care AFH LLC	02/29/2024

Findings included...

In an interview on 01/10/2024 at 9:39 AM, Staff B, Caregiver stated that they were in charge of the AFH with six residents (Residents 1, 2, 3, 4, 5, and 6) who lived and received care from the staff. Staff B stated that Staff C, Caregiver worked with them on that day.

In an interview on 01/10/2024 at 10:50 Am, Staff A, Entity Representative/Resident Manager stated that all six residents required assistance with emergency evacuation.

Record review on 01/10/2024 of AFH 2023 emergency evacuation drill showed completed drills on 09/29/2023 labelled as partial drill with five residents and four staff, on 07/30/2023 labeled as partial drill with six residents and three staff, on 05/30/2023 labeled as partial drill with six residents and five staff, on 03/31/2023 labeled as partial drill with six residents and four staff, on 01/30/2023 labeled as partial drill with five residents and one staff. The records were missing a completed full evacuation drill.

In an interview on 01/10/2024 at 6:19 PM, Staff A stated that they completed a November 2023 emergency evacuation drill and misplaced the document.

In an interview on 01/10/2024 at 6:22 PM, Staff A confirmed that they did not have the November 2023 emergency evacuation drill.

Attestation Statement

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

Provider (or Representative) 03/08/2024 Date