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

06/13/2025

Agave Adult Family Home LLC
Agave Adult Family Home LLC
1813 Davis Ave S
Renton, WA 98055

RE: Agave Adult Family Home LLC # 755358

Dear Provider:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 61105 (Completion Date 06/13/2025) and 57098 (Completion Date 04/15/2025).

The Department completed a follow-up inspection of your Adult Family Home on 06/13/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10225 Reporting requirement.

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

(b) Report the following to the department by calling the complaint toll-free hotline number:

(iii) A missing resident.

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

The Department staff who did the On Site verification:
Jennifer Domingo, AFH Complaint Investigator

If you have any questions, please contact me at (253)234-6033.

Sincerely,

Cecile Leano, Field Manager
Region 2, Unit E
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

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 03/27/2025 of:

Agave Adult Family Home LLC
1813 Davis Ave S
Renton, WA 98055

This document references the following complaint number(s): 171303, 174497

The following sample was selected for review during the unannounced on-site visit: 5 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Domingo, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit E
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.

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) | Date

WAC 388-76-10225 Reporting requirement.

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

(b) Report the following to the department by calling the complaint toll-free hotline number:

(iii) A missing resident.

This requirement was not met as evidenced by:

Based on observation, interviews, and record review, the Adult Family Home (AFH) failed to report to the Department Complaint Resolution Unit (CRU [Department hotline]) or completed an online report as required when 1 of 1 resident (Resident 1) went missing twice. This failure placed Resident 1 at risk of harm and unmet care needs.

Findings included…

On 03/27/2025 at 5:20 PM, observation showed Resident 1 returned to the home from their dialysis (a medical procedure that filters waste products and excess fluid from the blood when the kidneys are unable to perform this function) treatment without a balance problem and assistive device.

Record review of Resident 1's assessment dated 01/06/2025, showed Resident 1 had multiple medical diagnoses, which include [redacted] and [redacted] and required dialysis three times a week. The assessment showed Resident 1 had a memory problem due to poor decisions and was unaware of the consequences. Assessment further showed Resident

1 made poor decisions such as engaging in polysubstance (refers to the use of two or more drugs in combination, which can lead to serious health risks and complications) use as well as skipping dialysis, resulting in edema (swelling caused by too much fluid trapped in the body's tissues) and hospital stays.

Record review of AFH Incident Log showed the following Resident 1's incidents:
•[redacted]/2025 was missing, Resident 1 called AFH letting them know they were at the hospital on [redacted]/2025
•03/24/2025 was missing, and returned on 03/25/2025 at 6:00 AM

In an interview on 03/27/2025 at 5:22 PM, Resident 1 stated that they went out of state on [redacted]/2025 and were supposed to return [redacted]/2025 before their dialysis day on [redacted]/2025 but they took longer to return than expected because there was no train to return to home for two days. Resident 1 stated that when they returned to Washington on [redacted]/2025, they felt sick and weak at the train station and had to ask someone to call the Emergency Medical Services (EMS) for them. EMS brought them to the hospital and discharged them back to the home on [redacted]/2025. Resident 1 stated that they did not have a cell phone to call AFH to let them know where they were.

In an interview on 03/27/2025 at 5:25 PM, Staff A, Provider, stated that they did not notify anyone when Resident 1 did not return as expected from out of state. Staff A stated that Staff B, Caregiver, notified Resident 1's Department Case Manager.

In an interview on 04/08/2025 at 2:15 PM, Staff B stated that Resident 1 was supposed to return on [redacted]/2025 but missed their train. Staff B stated that they went to the train station to pick Resident 1 on [redacted]/2025 at around 3:00 PM but they were not there. Staff B stated that they asked Resident 1's Department Case Manager what to do when they could not locate where Resident 1 was. Staff B stated that they were not aware they had to notify the Department hotline when Resident 1 was missing.

In an interview on 04/09/2025 at 1:03 PM, Resident 1 stated that they left the afternoon on 03/24/2025 with Metro Access transportation (a shared-ride, door-to-door, paratransit service for eligible customers whose disability prevents them from using bust or rail) to a community health center. Resident 1 stated that they missed their Metro Access ride pick-up time to return home because they did not notice the time. Resident 1 stated that they rode a Metro bus going back home but slept on the bus, missed the stop drop off, and went farther. Resident 1 stated they had to wait for 5:00 AM the next day to get a metro bus ride back to AFH. Resident 1 stated that they returned home at 6:00 AM.

In an interview on 04/09/2025 at 3:34 PM, Staff A stated that they did not call the Department hotline the second time Resident 1 was missing because Resident 1 returned home within 24 hours. Staff A stated that Resident 1 did not elope because they were not at risk for elopement, they knew where to return home, and it was not intentional for them not to return on time.

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, Agave Adult Family Home LLC 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 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on observations, interviews, and record review, the Adult Family Home (AFH) failed to ensure 1 of 1 Resident's (Resident 1) Negotiated Care Plan (NCP) was updated when they missed their dialysis (a medical procedure that filters waste products and excess fluid from the blood when the kidneys cannot perform this function) and Methadone medication treatments (used to help relieve symptoms from other drugs, but it can also cause severe withdrawal symptoms if stopped too quickly) because they did not return from out of state to the home at the right time. This failure resulted in Resident 1's hospitalization and unmet care needs.

Findings included…

On 03/27/2025 at 5:07 PM, observation showed five residents (Resident 1, 2, 3, 4, and 5) and one staff member (Staff C, Caregiver) were in the home.

Record review of Resident 1's assessment dated 01/06/2025, showed Resident 1 had a medical diagnosis that impaired their cognition. The assessment showed Resident 1 physical/mental function fluctuates; he forgets to take their medications and makes poor decisions/is unaware of the consequences. The assessment showed Resident 1 required access to the Methadone clinic.

Record review of the Hospital record dated [redacted]/2025 showed Resident 1 was admitted to the hospital on [redacted]/2025 and discharged to AFH on [redacted]/2025 with a diagnosis of [redacted]

[redacted].

Record review of Medication Administration Record dated 03/2025 showed Resident 1 received medications every day at 7:30 AM, 8:00 AM, 12:00 PM, 5:00 PM, and 8:00 PM.

In an interview on 03/27/2025 at 5:22 PM, Resident 1 stated that they went out of state on [redacted]/2025 and were supposed to return before their dialysis day on [redacted]/2025, but they missed their first train ride returning home. Resident 1 stated that there were no trains for two days. Resident 1 stated that when they returned to Washington State on [redacted]/2025, they felt sick and weak at the train station and had to ask someone to call the Emergency Medical Services (EMS) for them. EMS brought them to the hospital and discharged them back to the home on [redacted]/2025. Resident 1 stated that they also had a withdrawal from missing their methadone medication.

In an interview on 04/08/2025 at 2:19 PM, Staff B, Caregiver, stated that Resident 1 was given seven days' supply of their medications, including Methadone, when they went out of state on [redacted]/2025. Staff B stated that Resident 1 only had a Methadone dose until Tuesday, [redacted]2025. Staff B stated that Resident 1 missed their train transportation to return the first time. Staff B further stated that on [redacted]/2025, Resident 1 did not show up when they went to pick them up at the train station. Staff B stated that Resident 1 called them on [redacted]/2025 and said that they were at the hospital and returned home the next day.

In an interview on 04/09/2025 at 1:03 PM, Resident 1 stated that they left AFH the afternoon on 03/24/2025 with Metro Access transportation (a shared-ride, door-to-door, paratransit service for eligible customers whose disability prevents them from using bust or rail) Resident 1 stated that they missed their Metro Access ride pick-up time to return home because they did not notice the time. Resident 1 stated that they rode a Metro bus going back home but slept on the bus, missed the stop drop off, and went farther. Resident 1 stated that they had to wait for 5:00 AM the next day to get a metro bus ride back to AFH. Resident 1 stated that they returned home at 6:00 AM. Resident 1 added that they missed their evening medications on 03/24/2025 because they did not make it home the same day.

In an interview on 04/09/2025 at 3:34 PM, Staff A, Provider, stated that they did not update Resident 1's Negotiated Care Plan (NCP). Staff A stated that Staff B was responsible for updating Resident 1's NCP. Staff A stated that Resident 1 left in the afternoon on 03/24/2025 and did not return home until 6:00 AM 03/25/2025. Staff A stated that Resident 1 missed their bedtime medications on 03/24/2025.

Record review of Resident 1's NCP, dated 11/01/2024, showed Resident 1 signed and dated it on 11/01/2024. The NCP did not show a revision to address Resident 1's missing dialysis and medications when they went out of state and went missing on [redacted]2025, which caused them hospitalization, to prevent reoccurrence and keep them safe. The NCP did not

show what interventions to follow when Resident 1 missed their Methadone treatment.

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, Agave Adult Family Home LLC 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