STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

MYONG LEWIS
KIMS ADULT FAMILY HOME
4814 88th Avenue Ct W
University Place, WA 98467

RE: KIMS ADULT FAMILY HOME License # 551900

Dear Provider:

This letter addresses Compliance Determination(s) 27726 (Completion Date 08/07/2023) and 19025 (Completion Date 05/16/2023).

The Department completed a follow-up inspection of your Adult Family Home on 08/07/2023 and found that you have corrected the violations listed in the Complaint report dated 05/16/2023. Your home is back in compliance as of 06/27/2023 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 388-76-10205

The Department staff who did the on-site verification:
Ibe Hatch, Licensor
Keyondra Okeke, AFH Compliant Investigator

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

Sincerely,

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

Residential Care Services
Investigation Summary Report

Provider/Facility: KIMS ADULT FAMILY HOME
License/Cert.#: 551900
Compliance Determination #: 19025
Investigator: Ibe Hatch
Investigation Date(s): 01/24/2023 through 05/16/2023
Complainant Contact Date(s):

Provider Type: Adult Family Home

Intake ID: 65843
Region/Unit #: RCS Region 3 / Unit A

Allegation(s):

Reporter requested staffing schedules for clients to ensure 1:1 staffing was provided per existing Medicaid contracts of Exception to Rule (ETR) and Specialized Behavior Support (SBS), including nights. There did not appear to be adequate staff available to provide the clients 1:1 care over the day and night.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	General environment, 5 residents, staff-to-resident interactions.
Interviews:	4 residents including SBS and ETR residents, resident manager, provider, Case Manager.
Record Reviews:	2 SBS and 4 ETR residents, negotiated care plans, January, February & March 2023 staffing schedules, residents' activity schedules SBS & ETR contract requirements.

Investigation Summary:

Interviews with residents revealed they had no complaints about their care, liked living in the adult home. Record review showed residents had activity schedules. Review of staffing schedules for January and February 2023 showed staff were scheduled for days and nights; however, interviews with two residents revealed they did their own activities. Review of March 2023 staffing scheduled included one staff on duty for general care of all residents and one staff for SBS clients. The staffing schedule did not allow extra caregivers for ETR residents. One SBS client was gone from the facility four afternoons in January and February and did not receive SBS services.
Citation written for 388-76-10205 because the conditions of the Medicaid contract were not met.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: KIMS ADULT FAMILY HOME
License/Cert.#: 551900
Compliance Determination #: 19025
Investigator: Ibe Hatch
Investigation Date(s): 01/24/2023 through 05/16/2023
Complainant Contact Date(s):

Provider Type: Adult Family Home

Intake ID: 68391
Region/Unit #: RCS Region 3 / Unit A

Allegation(s):

1. The Named Resident (NR) is not getting the 6-8 hours of 1:1 care as directed and stated in their negotiated care plan (NCP).

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Activities Dining Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Resident Manager Residents Reporter Case Manager
Record Reviews:	Negotiated Care Plan (NCP) Assessment Staff Schedules Medical Records

Investigation Summary:

1. Based on observation, interview, and record review, the NR is not receiving 1:1 care as directed and stated in their NCP. The NR had been out of the Adult Family Home (AFH) during 1:1 care hours. The AFH does not have adequate staffing to provide 1:1 care to the NR. Failed facility practice was identified.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 551900	Compliance Determination # 19025
Plan of Correction	KIMS ADULT FAMILY HOME	Completion Date
Page 1 of 7	Licensee: MYONG LEWIS	05/16/2023

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 01/24/2023 and 03/16/2023 of:

KIMS ADULT FAMILY HOME
4814 88th Avenue Ct W
University Place, WA 98467

This document references the following complaint number(s): 65843, 68391

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:

Ibe Hatch, Licensor
Keyondra Okeke, AFH Compliant Investigator
Lisa Cramer, Adult Family Home Field Manager

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit A
PO Box 99250
Lakewood, WA 98496

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.

Staci Dilley, IDR PM for Reg 3A — June 26, 2023

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 388-76-10205 Medicaid or state funded residents. When the adult family home accepts medicaid or state funded residents, the home must follow the terms and conditions of the department contract and chapter 388-105 WAC.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews the adult family home (AFH) failed to ensure they followed the terms and conditions of their Specialized Behavior Support (SBS) contract for 2 of 4 residents [Resident 2 (R2) and Resident 3 (R3)] receiving SBS services and their department contract for 4 of 4 residents, [Resident 1 (R1), Resident 2 (R2), Resident 3 (R3) and Resident 4 (R4)] receiving wrap around supports/funding for Behavioral Health Personal Care (BHPC) when only two staff were scheduled in March. This failure placed all of the residents at risk for unmet care needs.

Findings included...

Review of the SBS contract included requirements, "the AFH hire additional staff to provide direct support to the SBS client for a minimum of six hours per day (6-8 hours as noted in the contract). SBS activities are to be something in addition to services that are not care needs or tasks assigned already to be provided by the caregiver, and are not to be activities a client can do independently. Specific activities and hours are required to be planned and scheduled."

Review of the BHPC request specify the need for "1-1 care staff for safeguarding and assisting the client(s) over the course of the day and night." The BHPC request was a separate funding for staffing and support from the SBS contract.

According to the Case Manager on 03/08/2023, at 1:55 p.m., four residents in the adult home had BHPC funding for extra supports, R1, R2, R3 and R4. In addition, R2 and R3 had SBS services. Additional monies were paid for both services (SBS and BHPC).

Resident 1 (R1)
On 01/24/2023, at 10:30 a.m., R1 was observed lying in bed. R1 was not interviewable due to their diagnoses (see below).

Record review showed R1 was admitted to the adult home with diagnoses including [redacted], among others. R1's assessment dated 09/03/2021, documented behaviors including: combative during personal care, assaultive, throws things, disrupts household at night when others were sleeping requiring intervention; resident was getting up at night and coming out of their bedroom and going into other resident bedrooms, easily irritated/agitated, hallucinations, intentional self-injury, and pacing. R1 required one-person assistance with walking and personal hygiene, total assistance with dressing, eating, and bathing.

Review of the Behavioral Health Personal Care (BHPC) Request for additional funding dated 10/03/2021:
The client continues to pose a risk to self and others through assaultive behaviors that are exacerbated [worsened] by [their] visual impairment. [They] continue to require extra staff to manage behaviors while providing personal care needs in a safe manner during personal care and meals. Specific behaviors addressed were breaking cups, banging [their] head into walls and tables, hitting [their] head with [their] own hands and physical aggression at other residents. Overnight the client enters other resident's rooms and requires supervision and redirection. Behavioral health symptoms of hallucinations and response to internal stimuli during personal care often posed threats to caregivers as acts of assaultive behavior were unpredictable and resulted in striking at staff often without warning. One on one care staff were needed for safeguarding and assisting from a removed but available presence. The client was triggered and agitated by engagement; responded well to support when needed and client became agitated by constant one on one supervision. Over the course of the day and night staff monitor and redirect the client while [they] move about the shared space to assure safety of others in the home and for the client [themselves]. Current care provider was effective at deescalating behaviors, providing familiar environment and routine while mitigating risks associated with impulsivity and aggression. Routine and rapport have been essential in reducing occurrences of behaviors and minimizing consequences when they occur.

Resident 2 (R2)
Record review showed R2 was admitted to the AFH [redacted] 2019. R2's assessment dated 03/03/2022, showed diagnoses including [redacted] Behaviors documented included: disrupted household at night, arising around 2:00 a.m. and required intervention, auditory hallucinations (hearing voices or noises not there), and self-injury, among others.

On 01/24/2023, at 11:00 a.m., R2 was observed lying in bed. On 01/24/2023, at 11:00 a.m., during an interview, R2 said they played games on their tablet, talked to friends on messenger, spent a lot of time in their bedroom, watched TV, and did [redacted] study once a week with Staff B.

In an interview on 3/27/2023 at 2:19 PM, when asked about their activities, R2 answered that they participated in word searches, study vocabulary words, and occasionally watched

the Netflix program Manifest with their housemates. The AFH staff gave R2 a goal/vision board, which they were currently working on. They participated in card games like Uno and checkers with the other residents of the home. On their tablet, they regularly engaged in independent gaming. R2 said most of the time they spent on activities was spent alone. Additionally, R2 talked to the provider about mental health issues for up to three hours each week.

Record review showed R2's SBS contract required the provider to have a 1:1 staff for this resident 6-8 hours per day which was scheduled by the adult home from 6:00 a.m. to noon.

Review of an BHPC request dated 02/13/2023, was made to continue facilitating R2's care, with R2's current $200 BHPC rate (in addition to the regular rate and SBS rates) for prompted assistance needed to facilitate R2's Daily Living. The BHPC request noted R2 had multiple, constant, and extreme behaviors requiring about 18 hours of close supervision and redirection every day. R2's behaviors included: suicidal ideation of plans to set themselves on fire or taking overdoses of drugs/alcohol and disappear. R2 had a suicide prevention plan. R2 was easily irritated/agitated and often intolerant to others, exhibited unrealistic fears and suspicions, easily frustrated, usually impatient with others and had difficulties understanding situations/processes/others. When frustrated, R2 would usually respond with anger, and verbal aggression requiring intervention. R2's behavior escalated easily and would usually result in household disruption. R2 was not easily redirectable and would exhibit intermittent verbal aggression. Frequency: daily, usually throughout the day, and at least twice every night, behavior was not easily altered.

According to the Resident Manager (RM) on 04/26/2023, at 10:50 a.m., R2 may not need help at 6:00 a.m., because R2 woke in the night around 2:00 a.m., and 1:1 assistance was needed for an undetermined amount of time. It was unclear how many hours R2 needed 1:1 assistance.

Resident 3 (R3)
Record review showed R3 was admitted to the AFH [redacted]/2019, with diagnoses including [redacted] and [redacted], among others.

R3 was observed on 01/24/2023, at 11:20 a.m., sitting on the edge of their bed. On 01/24/2023, at 11:20 a.m. during interview, R3 said they played checkers and UNO (card game) with Resident 4, did puzzles, and read a lot.

R3's BHPC included: "The client continues to have persistent delusions about [R3's] role in relation to others, and pre-occupation with politically philosophical ideas. These beliefs were not easily altered and associated with behaviors that required staff intervention to assure safety and wellbeing of others in the home." Specific behaviors included yelling, screaming, loudly reading from text, playing [redacted] music so loudly it woke the other residents, banging R3s walker into the walls and furniture, attempting to enter the rooms of other residents, becoming agitated, intimidating and threatening AFH staff and residents, threatening violence such as threats "to slit throats," becoming highly anxious,

throughout the course of the day and night. Hoarding behaviors continued to require staff intervention to provide a safe environment for the client and other AFH residents. The client became very passionate about the importance of abundant items and was frequently reluctant to adhere to house rules pertaining to items stored, maintaining walkways, exits. These behaviors were not easily altered. Constant monitoring, redirection and assurance was used to respond to signs of hoarding behavior.

Record review showed sexually inappropriate behavior was an ongoing challenge that required constant monitoring beyond the use of SBS 1:1 hours. A medical diagnosis of [redacted] exacerbated this behavior due to the need to urgently use the bathroom at night that required staff assistance to maintain boundaries, and guide the resident to the bathroom and back to their room. R3 often being up, opened other residents' doors at night, most commonly two female residents. R3 had delusions of their relationship with female residents at the AFH, often believed they were R3's girlfriend and attempted to enter their bedrooms. R3 requested sexual acts be performed, and often began to masturbate in shared areas.

Record review of documentation received from R3's group session agency showed R3 went to group sessions out of the AFH, four afternoons in January, and four afternoons in February 2023.

In an interview on 4/18/2023 at 11:40 a.m., R3 stated that R3 was not accompanied by AFH staff when R3 left the facility at around 2:00 p.m. and returned at 5:30 p.m. In January and February 2023, R3 was absent from the AFH for three and a half hours four times per month, and SBS services were not provided during those periods. R3 added that they carried out most of their activities alone. Reading, crossword puzzles, going outside for walks when the weather allows, food shopping, and doctor's appointments were among R3's reported activities.

In an interview on 04/26/2023, at 11:35 a.m., the RM said they made up the SBS hours the next day from 6:00 p.m. to 8:00 p.m., but it was unclear how the time was made up and it did not equal three and one-half hours.

Resident 4 (R4)
On 01/24/2023, at 10:45 a.m., R4 was observed walking around in the adult home independently.

Record review showed R4's assessment dated 02/16/2022, included diagnoses of [redacted] as well as [redacted] among others. The assessment noted behaviors that were not easily altered, occurred daily, included delusions, persistent hallucinations, getting up at night, turned lights on and made a lot of noise which was disruptive to other residents, had extreme, rapid, unpredictable mood swings with sudden onset, often resistive to staff requests/recommendations and would often leave the home

when asked not to, and at inappropriate times.

Review of R4's BHPC documented the following which closely matched R4's assessment above: R4 has a diagnosis of [redacted] and [redacted] requiring 1:1 support redirecting their behaviors. R4 had paranoid delusions and believed people talked about R4 and stole their belongings. R4 disrupted the household at night banged on cupboards, turned lights off and on, paced; became easily agitated and irritated often shutting down and regressing into a child-like state, had sudden and rapid mood swings throughout the day-caregivers were unable to understand R4 when in this state; had hallucinations and talked to their self and laughed a lot, dumpster dived, brought garbage and miscellaneous items back to the AFH; could be resistive to care with words and gestures, and often left the AFH at inappropriate times.

According to the AFH's 03/02/2023, March schedule revision, Staff A was scheduled from 8:00 a.m., to 8:00 p.m., and from 4:00 p.m. to 8:00 a.m., for general resident care, Monday through Saturday. Staff B was scheduled for SBS R2 from 6:00 a.m. to noon, and from noon to 6:00 p.m., for SBS R3 Monday through Saturday. Both Staff A and Staff B were scheduled as routine staff 6:00 p.m. through 8:00 a.m., Monday through Sunday.

If one caregiver was needed for SBS R2, and another caregiver was needed for SBS R3, there was not another caregiver assigned to the general care/BHPC care for the other residents.

On 04/26/2023, at 10:50 a.m., when asked how caregivers could be expected to work 24/7 for five plus days in a row, the Resident Manager (RM) said one slept at night.

In an interview on 04/26/2023, at 11:35 a.m., the RM said they had two caregivers in March because one had to take emergency leave. The RM stated all the residents received sufficient care. Review of the staffing schedule made it unclear how the demands of the residents' needs were met.

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, KIMS ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 6/27/2023.

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

Provider (or Representative) — Date: 6/27/2023.