



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 98907, Lakewood, WA 98496

April 26, 2016

KONG CHI
CHI ADULT FAMILY HOME
13617 109TH ST CT E
PUYALLUP, WA 98374

RE: CHI ADULT FAMILY HOME License #750304

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 14, 2016 for the deficiency or deficiencies cited in the report/s dated January 27, 2016 and found no deficiencies.

The Department staff who did the inspection:
Kathleen Edder, Adult Family Home Licensors

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

Sincerely,

A handwritten signature in cursive script that reads "Lisa Cramer".

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



STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 AGING AND LONG-TERM SUPPORT ADMINISTRATION
 PO Box 98907, Lakewood, WA 98496

RECEIVED
 FEB 05 2016
 DSHS RCS Region 3

Statement of Deficiencies	License #: 750304	Completion Date
Plan of Correction	CHI ADULT FAMILY HOME	January 27, 2016
Page 1 of 10	Licensee: KONG CHI	

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

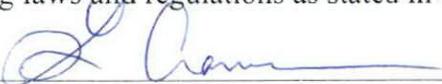
The department has completed data collection for the unannounced on-site full inspection of:
 1/13/2016

CHI ADULT FAMILY HOME
 13617 109TH ST CT E
 PUYALLUP, WA 98374

The department staff that inspected the adult family home:
 Kathleen Edder, Adult Family Home Licensors

From:
 DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit A
 PO Box 98907
 Lakewood, WA 98496
 (253)983-3826

As a result of the on-site full inspection 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	<u>1/29/16</u> Date
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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)	<u>2-3-16</u> Date
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~~03/29~~
03/27

WAC 388-76-10146 Qualifications Training and home care aide certification.

(3) All persons listed in subsection (2) of this section, must obtain the home-care aide certification if required by this section or chapters 246-980 or 388-112 WAC.

(a) Until March 1, 2016, a provisional home-care aide certification may be issued by the department of health to a long-term care worker who is limited English proficient.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure 1 of 5 caregivers (C) had obtained certification as required by WAC 388-112. This failure placed 5 of 5 residents (#1, #2, #3, #4, and #5) at risk for receiving services from inadequately trained staff.

Findings include:

All interview and record review took place on 1/13/16 unless otherwise noted.

Record review revealed Caregiver C had been hired on [REDACTED] 15. There was no documentation in his employee file to indicate he had completed any certification as required by WAC 388-112, including Home Care Aide Certification or Nursing Assistant Certified training.

Caregiver C had been employed by the AFH for 257 days, and had exceeded the 200 allowable days per WAC 246-980-050 by 57 days.

When interviewed, the Provider said Caregiver C had completed the Nursing Assistant Certification courses at the local college, but had not taken the test due to illness, and had no plans to reschedule another test date. The Provider said he did not realize there was a time limit under which Caregiver C could work without certification.

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, CHI ADULT FAMILY HOME is or will be in compliance with this law and / or regulation on (Date) 3/29/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

Chi Kong
Provider (or Representative)

2-3-16
Date

WAC 388-76-10430 Medication system.

(3) Records are kept which include a current list of prescribed and over-the-counter medications including name, dosage, frequency and the name and phone number of the practitioner as needed.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the adult family home (AFH) failed to ensure there was a current list of medications in the records for 5 of 5 residents (#1, #2, #3, #4, and #5). This

placed the residents at risk for medical complications from not receiving their medications as ordered by their physicians.

Findings include:

All interviews and record reviews took place on 1/13/16 unless otherwise noted.

Resident #1:

Resident #1 was admitted to the home on [REDACTED] 14 with diagnoses including [REDACTED] among others.

Record review of her annual assessment dated 7/20/15 noted her medication management level as "Self-Administration, Assistance required." Her assessment said she was "aware of frequency and dosages," but her "ability fluctuates."

Record review revealed no current list of medications that could be reconciled with the resident's Medication Administration Record (MAR) in her chart.

Resident #2:

Resident #2 was admitted to the home on [REDACTED] 07 with diagnoses including [REDACTED] among others.

Record review of her annual assessment dated 1/7/16 noted her medication management level as "Self-Administration, Assistance required." Her assessment said she had a "complex regimen" and "does not follow frequency or dosage."

Review of Resident #2's MAR noted 4 medications that had been discontinued according to the Provider's notes. The

Provider also reported 2 additional medications on the MAR he said the resident refused to take because "they didn't work" and were "too expensive." When asked why these medications were still on the MAR, the Provider said the pharmacy had not removed them.

Record review revealed no current list of medications that could be reconciled with the resident's MAR in her chart. The Provider said when Resident #2 returned from her physician's visits, she usually kept the visit paperwork with her in her room. The resident was sleeping most of the afternoon and unable to wake up enough to provide paperwork for review.

Resident #3:

Resident #3 was admitted to the home on [REDACTED] 15 with diagnoses including [REDACTED] and [REDACTED] among others.

Record review of her annual assessment dated 10/26/15 noted her medication management level as "Self-Administration, Assistance required." Her assessment said: "ability fluctuates," "does not follow frequency or dosage," "on psychotropic drug needing monitoring," and "forgets to take medications."

Record review revealed no current list of medications that could be reconciled with the resident's MAR in her chart.

Resident #4:

Resident #4 was admitted to the home on [REDACTED] 12 with diagnoses including [REDACTED] among others.

Record review of his annual assessment dated 9/22/15 noted his medication management level as "Self-Administration, Assistance required." His assessment said: "ability fluctuates," "does not follow frequency or dosage," "on psychotropic drug needing monitoring," "forgets to take medications," and "unaware of dosages."

Record review revealed no current list of medications that could be reconciled with the resident's MAR in his chart.

Resident #5:

Resident #5 was admitted to the home on [REDACTED] 07 with diagnoses including [REDACTED] among others.

Record review of his annual assessment dated 4/6/15 noted his medication management level as "Self-Administration, Assistance required." His assessment said: "on psychotropic drug needing monitoring," "forgets to take medications," and "unaware of dosages."

Record review revealed no current list of medications that could be reconciled with the resident's MAR in his chart.

When interviewed, the Provider said the MAR's for all the residents were printed by the pharmacy, and any changes to the residents' medications were communicated directly from their physicians to the pharmacy. The Provider stated he did maintain records of individual prescriptions and some medication change orders for each resident, but did not have an updated list of all the prescribed and over-the-counter medications he could use to reconcile the MAR's and actual medications for each resident.

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Provider (or Representative)

2-3-16

Date

WAC 388-76-10530 Resident rights Notice of services. The adult family home must provide each resident notice in writing and in a language the resident understands before admission, and at least once every twenty-four months after admission of the:

- (1) Services, items, and activities customarily available in the home or arranged for by the home as permitted by the license;
- (2) Charges for those services, items, and activities including charges for services, items, and activities not covered by the home's per diem rate or applicable public benefit programs; and
- (3) Rules of the home's operations.

This requirement was not met as evidenced by:

Based on observations, interview, and record reviews, the adult family home failed to ensure that the Notices of Services for 3 of 5 residents (#2, #4, and #5) were updated every 24 months. This failure placed the residents and/or their representatives at risk for being misinformed regarding the services provided by the home, the charges for the services, and the rules of the home's operations.

Findings include:

All observations, interviews and record reviews took place on 1/13/16 unless otherwise noted.

Resident #2:

Resident #2 was admitted to the home on [REDACTED] 07 with diagnoses including [REDACTED] and [REDACTED] among others.

Observations during the tour of home revealed Resident #2 sitting up in bed watching television. She was alert in the morning when introduced, and observations throughout the day noted she was able to call the Provider using her cell phone to request his assistance with various tasks.

Review of her most recent assessment dated 1/7/16 noted both her recent and long-term memory were "OK" and said she was able to supervise her caregivers.

Record review revealed her Notice of Services was most recently signed by the resident on 3/12/12, 46 months ago.

Resident #4:

Resident #4 was admitted to the home on [redacted] 2 with diagnoses including [redacted] and [redacted] among others.

Observations during the tour of the home revealed the resident in his room, watching television. When introduced, the Provider reported the resident spoke only [redacted]. Observations noted both the Provider and Caregiver A spoke [redacted] and were able to communicate with Resident #4.

Record review of his annual assessment dated 9/22/15 noted he had both recent and long-term memory problems.

Record review revealed his Notice of Services was most recently signed by his representative on 11/27/12, over 37 months ago.

Resident #5:

Resident #5 was admitted to the home on [redacted] 07 with diagnoses including [redacted] among others.

Observations during the inspection of the home revealed the resident stayed in the common areas of the kitchen and living room throughout the day. He was non-verbal, but responded appropriately to directions from the Provider and Caregiver A.

Record review of his annual assessment dated 4/6/15 noted both recent and long-term memory problems and difficulty making decisions.

Record review revealed his notice of Services was most recently signed by his representative on 3/21/12, over 45 months ago.

When interviewed, the Provider said he didn't realize the Notices of Services had not been updated and reviewed.

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Chi Kong
Provider (or Representative)

2-3-16
Date

WAC 388-76-10650 Medical devices. Before the adult family home uses medical devices for any resident, the home must:

- (1) Review the resident assessment to determine the resident's need for and use of a medical device;
- (2) Ensure the resident negotiated care plan includes the resident use of a medical device or devices; and
- (3) Provide the resident and family with enough information about the significance and level of the safety risk of use of the device to enable them to make an informed decision about whether or not to use the device.

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the adult family home (AFH) failed to ensure both assessments and one negotiated care plan (NCP) reflected the need for and use of overhead trapezes for 2 of 2 (#1 and #2) residents who used medical devices. The AFH also failed to obtain informed consents for the use of the trapezes from the residents. These failures placed the residents at risk for shoulder strain and injury from the use of these medical devices.

Findings include:

All observations, interviews, and record reviews took place on 1/13/16 unless otherwise noted.

Resident #1:

Resident #1 was admitted to the home on [REDACTED] 14 with diagnoses including [REDACTED]

[REDACTED] among others.

Observations during the tour of the home revealed two overhead trapeze systems attached to her bed. When asked about these, the Provider said the resident used the trapezes to help her reposition herself in bed. The resident also said she used the trapezes for repositioning.

Record review of the resident's most recent assessment dated 7/20/15 noted under the "Bed Mobility" section the resident "has" and "uses" a trapeze, and is "able to use trapeze." The assessment did not address the resident's need for the trapeze.

Review of Resident #1's NCP revealed mention of the trapeze system and the resident's use of it, but included no instructions for caregivers regarding when and how to help her to use it safely.

There was no documented informed consent signed by the resident or resident's representative.

Resident #2:

Resident #2 was admitted to the home on [REDACTED] 07 with diagnoses including [REDACTED]

[REDACTED] among others.

Observations during the tour of the home revealed an overhead trapeze system attached to her bed. When asked about these, both the resident and the Provider said she had it "for years" and used the trapeze to help her reposition herself in bed.

Record review of the resident's most recent assessment dated 1/7/16 noted under the "Bed Mobility" section the resident "has" and "uses" a trapeze. There was no mention of the need for or the use of the trapeze in the assessment. Elsewhere in the assessment it stated she [REDACTED]

Review of the resident's NCP revealed no mention of the use of the trapeze to assist with bed mobility.

There was no documented informed consent signed by the resident or resident's representative.

When interviewed, the Provider said he didn't realize he needed to have this documentation for overhead trapeze systems.

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Chi Kong
Provider (or Representative)

2-3-16
Date

WAC 388-76-101632 Background checks National fingerprint background check.

(1) Individuals specified in WAC 388-76-10161 (2) who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to ensure that 1 of 5 caregivers (C) had obtained the results of a national fingerprint background check. This failure placed 5 of 5 residents (#1, #2, #3, #4, and #5) at risk for unsupervised access by a person with a possible disqualifying criminal history.

Findings include:

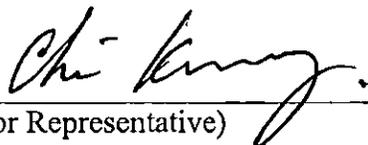
All interview and record review took place on 1/13/16 unless otherwise noted.

Record review revealed Caregiver C had been hired on [REDACTED] 15. Review noted he had the results of a Washington State name and date of birth background check that was reviewed on 4/13/15 (no negative findings, expiration date 4/13/17). There was no documentation regarding a national fingerprint background check in Caregiver C's file.

When interviewed, the Provider said he didn't realize they needed both a Washington State background check and a national fingerprint background for new hires.

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Provider (or Representative)

2-3-16

Date

WAC 388-112-0110 What is specialty training and who is required to take specialty training?

(1) Specialty or "special needs" training provides instruction in caregiving skills that meet the special needs of people living with mental illness, dementia, or developmental disabilities. Specialty trainings are different for each population served and are not interchangeable. Specialty training may be integrated with basic training if the complete content of each training is included. DSHS must approve specialty training curriculums for managers and long-term care workers.

(3) All long-term care workers including those who are exempt from basic training and who work in an assisted living facility or adult family home, serving residents with the special needs described in subsection (2) of this section, must take long-term care worker specialty training. The long-term care worker specialty training applies to the type of residents served by the home as follows:

- (a) Developmental disabilities specialty training, described in WAC 388-112-0120 .
- (b) Long-term care worker dementia specialty training, described in WAC 388-112-0130 ; and
- (c) Long-term care worker mental health specialty training, described in WAC 388-112-0140 .

This requirement was not met as evidenced by:

Based on observations, interviews, and record reviews, the adult family home (AFH) failed to ensure 2 of 5 caregivers (A and B) had documentation as required by WAC 388-112-0155 to verify they had successfully completed specialty training courses. This failure placed 5 of 5 residents (#1, #2, #3, #4, and #5) at risk for receiving services from inadequately trained staff.

Findings include:

All observations, interviews, and record reviews took place on 1/13/16 unless otherwise noted. The AFH was licensed 2/1/07 and had specialty designations for Developmental Disabilities, Dementia, and Mental Health.

Caregiver A:

Observations during the inspection of the home revealed Caregiver A working in the home

throughout the day preparing meals, cleaning, providing stand-by assistance with resident ambulation, and interacting with residents.

Record review revealed Caregiver A was hired on 6/26/07; she is the wife of the Provider and had been working in the home since its inception. Review of her file noted no documentation she had completed any of the specialty training courses.

Caregiver B:

Observation during the inspection of the home revealed Caregiver B working in the home throughout the day interacting with residents and assisting with administrative duties.

Record review revealed Caregiver B was hired on 11/1/07. Review of her file noted no documentation she had completed any of the specialty training courses.

When interviewed during the inspection of the home, the Provider and both caregivers said they were sure the trainings had been completed, but were not able to produce the documentation. Record review discovered a letter faxed to the department dated 6/16/14 that stated the Provider had completed "Dementia and Mental Health training" for both Caregivers A and B on 6/10/13.

When interviewed by phone on 1/15/16, the Provider said he was authorized to provide training by the Department of Social and Health Services in Washington. Review of his credentials revealed he was approved for Continuing Education and Orientation and Safety training, but not for Specialty Trainings. When notified of this, the Provider said he would have Caregivers A and B complete the trainings right away.

Attestation Statement

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Provider (or Representative)

Chi Kong

Date

2-3-16