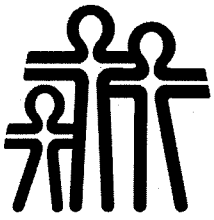
JLEC Response ESSB 6052



Washington State
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ALTSA Aging and Long-Term
Support Administration

(10)(f)(i) A description of the oversight role for Residential Care Services, the Long-Term Care Ombuds, the Centers for Medicare and Medicaid Services, and Disability Rights Washington;

- Residential Care Services (RCS) Overview Sheet
- RCS Purpose Statement – Fact Sheets
- DSHS Regional Map
- Long-Term Care Ombuds
    - Provided by Patricia Hunter, LTCOP Director
- Center for Medicare & Medicaid Services
    - Published on CMS.gov website
- Disability Rights Washington
    - Provided by David Lord, Director of Public Policy

Washington State Department of Social and Health Services

Transforming Lives

Residential Care Services

The Aging and Long-Term Support Administration's Residential Care Services Division is responsible to protect and promote the health, safety, and well-being of individuals who are vulnerable and residing in Washington State's 3,700 facilities statewide. These include adult family homes, assisted living facilities, nursing homes, intermediate care facilities for individuals with intellectual disabilities, certified residential/supported living programs, and enhanced services facilities.

Residential Care Services provides comprehensive regulatory oversight, licensing, and certification of facilities. This includes investigating complaints and conducting timely surveys and enforcement activities related to facility/provider practice. These essential functions are performed using state and/or federal regulations; and in partnership with the entities including the Department of Health, the Washington State Long-Term Care Ombuds Program, Law Enforcement, Adult Protective Services, and the Attorney General's Office.

A professional team, comprised of over 300 nurses, social workers and managers conduct the in-person surveys/inspections, while delivering detailed reports outlining any deficiencies in practice and enforcement for Residential Care Services. At the forefront of staff interactions is to transform lives by promoting choice, independence, and safety through innovative services.

To reinforce a strong community safety network, Residential Care Services also relies on help from clients/residents, families, providers, Tribes, stakeholders and advocacy groups.

For more information on the Residential Care Services Division, please visit: https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services.

Washington State Department of Social & Health Services

Transforming lives

RCS Complaint Reporting & Investigation

Complaint Reporters

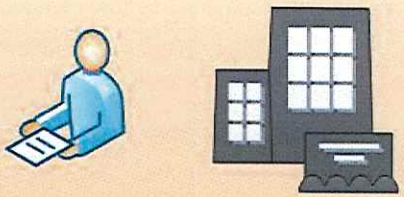
Provider Public Family Members

The Complaint Resolution Unit (CRU) hotline 1-800-562-6078 receives and prioritizes complaints regarding provider practice, including suspected abuse or neglect in long-term care settings including adult family homes, assisted living facilities, nursing homes, intermediate care facilities for individuals with intellectual disabilities, and certified residential/supported living programs.

Calls or contacts the RCS Complaint Resolution Unit (CRU) with concern or incident

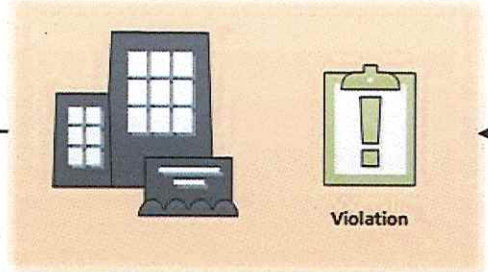
CRU Staff triage complaint and it may be assigned to the district field office for investigation

Complaint Investigation is conducted by RCS staff at the facility

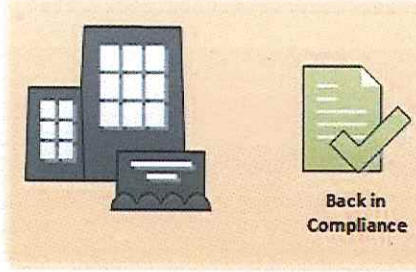


When an investigation is conducted, RCS checks for compliance with specific regulations that govern licensed/certified providers. Regulations address many important areas, but not all issues that impact a resident are potential regulatory violations.

If a violation is found, RCS may take enforcement action that ranges from imposing a monetary fine to revoking the license or certification.



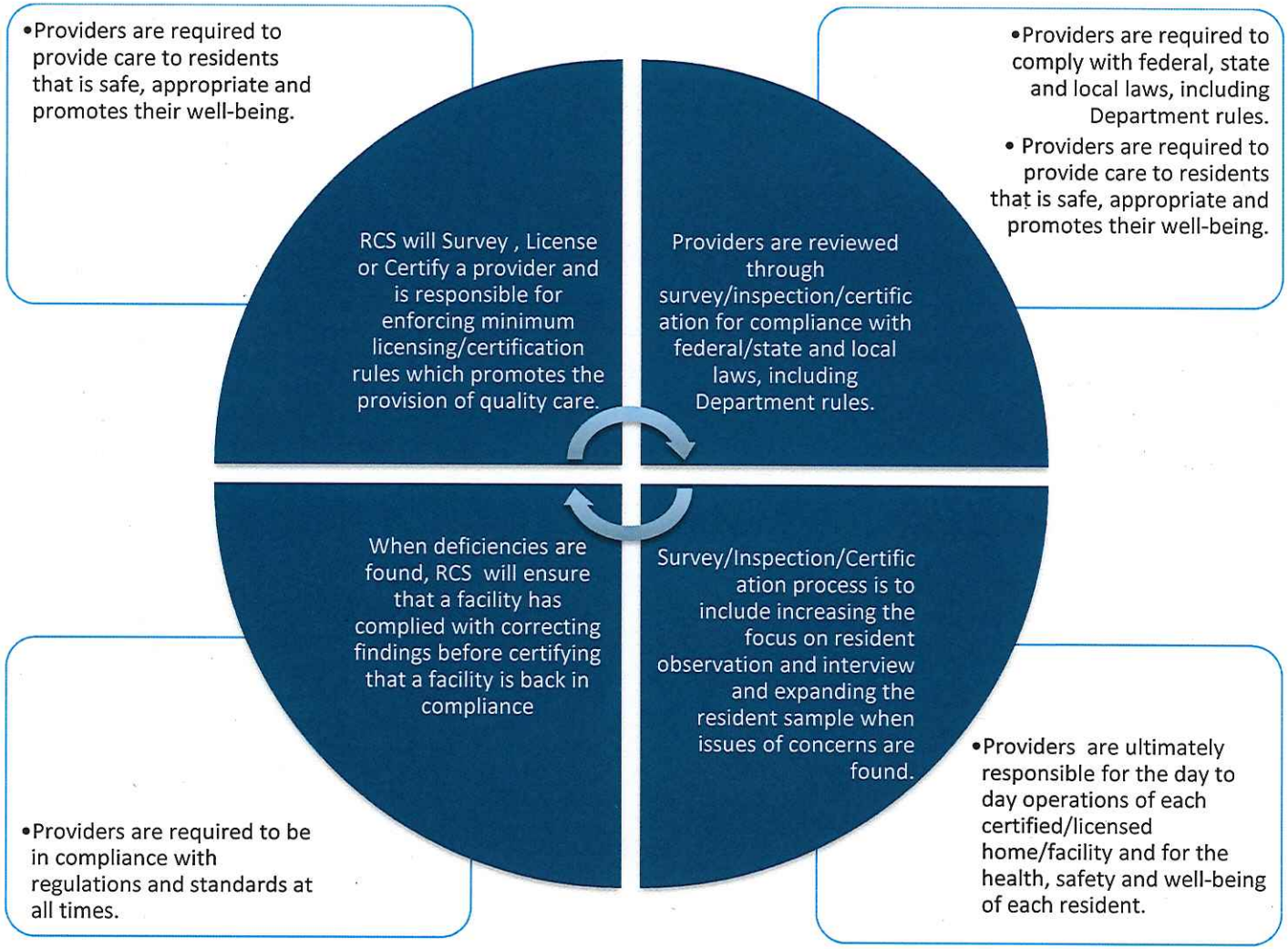
The facility may remedy the enforcement action with a plan of correction. Follow-up visits by are made to ensure that regulation violations are corrected and the provider is back in compliance



Depending on the nature and severity of the reported issue, reports may be referred to law enforcement, state professional licensing boards, Medicaid Fraud, Adult Protective Services or other state agencies.

Residential Care Services Licensing Overview

Residential Care Services is responsible for licensing and regulating over 3,600 long-term care residential providers/facilities in Washington State, including nursing homes (NHs), assisted living facilities (ALFs), and adult family homes (AFHs). RCS also certifies Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and certified residential/supported living providers. RCS conducts quality assurance activities to ensure residents are protected from abuse, neglect and exploitation through surveys, licensing and certification inspections.



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Aging and Long-Term Support Administration

Fact Sheet: Programs and Initiatives

Understanding the Licensing Process

Overview	Under state law, RCS is responsible for licensing and regulating over 3,600 long-term care residential providers/facilities in Washington state, including nursing homes (NHs), assisted living facilities (ALFs), adult family homes (AFHs) and enhanced services facilities (ESFs). RCS also certifies Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/IID) and certified community residential services and support (CCRSS) providers. All licensed applicants undergo a thorough process that includes: • Criminal background checks on all applicants and on individuals affiliated with an applicant who will have unsupervised access to residents. Individuals identified with disqualifying crimes will not be able to work unsupervised with vulnerable people. For CCRSS, out-of-state background checks are conducted for those who have lived outside of Washington state within the past 3 years. In ALFs and AFHs, a national fingerprint-based background check is also required for certain individuals. • Financial assessments to determine whether the applicant has enough funding available to operate the business so residents get the highest of care in the safest setting. These assessments also include a review of Master Business License records, Secretary of State records and IRS records. • Review of complaints received from DSHS or the state Department of Health (DOH) to identify issues of concern about the applicant; • Review of the status of the applicant's professional license, such as a registered nursing license, to check for actions taken against the license by DOH; • Review of compliance history to determine if the applicant has been a previously licensed provider and his or her historical compliance with state licensing requirements; • Verification that applicants have completed required courses and training; • Ensuring that the provider/caregivers have completed required education and training; • Verification that applicants have met the minimum hours of successful direct caregiving experience; • On-site inspections conducted to ensure facilities/homes are in compliance with licensing requirements; • Reviews by DOH and the State Fire Marshal of the structural and fire safety of NHs and ALFs; • Certification approval from the federal Centers for Medicare and Medicaid Services to allow nursing homes to care for Medicare or Medicaid clients.

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	DSHS is given statutory direction in RCW 43.20B.110(2) to charge fees that "…shall be based on, but shall not exceed, the cost to the department for licensure of the class of activity or class of activities and may include costs of necessary inspection." These fees, in combination with state and federal money, pay for state staff to perform the required quality asurance activities. Without this revenue, RCS could not maintain the staffing necessary to carry out these critical activities. The annual licensing for nursing homes, assisted living facilties, adult family homes and enhanced services facilities may fluctuate each year and are established in the state Omnibus Appropriations Act.
Eligibility	N/A
Authority	Chapter 388-76 WAC - Adult Family Homes Chapter 388-78A WAC – Assisted Living Facilities Chapter 388-97 WAC – Nursing Homes Chapter 388-107 WAC- Enhanced Services Facilities Chapter 388-101 WAC- Certified Community Residential Services and Support
Budget	N/A
Rates	N/A
Fiscal Year Cost/Numbers Served	N/A
Partners	Department of Health, Construction Review State Fire Marshal
Oversight	Inspections are done before the facility/home is licensed. The physical structure is reviewed, along with a review of policies and procedures in place to meet residents' physical, medical and emotional needs. Some of the licensing activities done during inspections include observation of care delivery, transfers, toileting, watching assistance given during dining, interviews of residents, families, and staff and attending activities with residents. RCS will conduct subsequent inspections if problems are identified that require on-site validation of corrections.

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Washington State
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Aging and Long-Term Support Administration

Fact Sheet: Programs and Initiatives

360 Quality Assurance

Overview	Residential Care Services (RCS) received 24 month funding (expiring in March 2016) for 6 FTEs from a Centers for Medicare and Medicaid Services (CMS) community living grant in order to develop and implement a structured, comprehensive quality assurance management system. This is the first time RCS has ever had a formal division-wide quality assurance system. The development of this system is critical in accomplishing the mission of promoting excellence in RCS. The QA unit is aligned with RCS' objective to have a fair, consistent, and efficient regulatory system that promotes positive outcomes. Continuous quality improvement of core processes and services ensure quality care and life for individuals residing in licensed and certified settings. The goals of the unit are to: • Join with our staff and system partners to create opportunities for positive program and system change. • Implement accountability review mechanisms and a universal tool to ensure the services provided by the Division are in compliance and consistent with federal, state, and agency rules and regulations. • Develop and deploy essential Quality Assurance tools and Proficiency Improvement Plans. • Schedule and conduct periodic conformance audits of the quality management tools and reports. • Establish effective Quality Assurance benchmarks to ensure robust risk management to address potential problems before they occur. QA 360 Unit began its first audit cycle in March 2015. QA 360 successes to date are as follows: • Conducted nursing home Statement of Deficiencies review and audited ASPEN tracking system data to identify if Statement of Deficiencies were mailed out on time (within 10 days). • Conducted audits of adult family home and assisted living facility to review SODS to determine if they met the Principles of Documentation (POD) standards and to determine if SODs were mailed timely. • Conducted a review of Adult Family Home licensing files to determine if Criminal Background checks were done during licensed home inspections. • Conducted a comprehensive hands-on review of AFH licensing inspections

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	files to determine if licensors followed SOPs related to licensing inspections. • Conducted an audit in the ICF-IID program to determine if surveys were timely and the SOD was done according the Principles of documentation standards. • Conducted an audit and re-audit of the Quality Review SOP. • Completed RCS' first Customer Service Feedback Initiative.
Eligibility Requirements	Residential Care Services and external stakeholders will benefit from this unit's quality assurance activities. Ultimately, residents who live in our licensed and certified long-term care settings will also benefit by ensuring the services. provided by the division are in compliance with federal, state and agency rules and regulations. An ongoing Quality Assurance Unit will be dedicated to consistent, measurable quality assurance practices, increased risk management practices, and independent internal reviews to ensure state performance measures and CMS expectations around quality management are consistently met. The QA unit will continue to implement accountability review mechanisms and monitor proficiency improvement plans to prevent the recurrence of repeat audit findings.
Authority	N/A
Budget	A project proposal for the implementation of a comprehensive quality assurance program was submitted and approved by the Centers for Medicare and Medicaid Services (CMS). The grant monies received to fund the Quality Assurance Unit are part of a larger federal grant managed by the Home and Community Services (HCS) Division through the *Roads to Community Living Program*. Funding is for six staff for two years at $720,000 per fiscal year.
Rates	N/A
Partners	360 QA will work with each provider association, as well as consumer advocacy groups such as Long-Term Care Ombuds. We are also partnering with Qualis Health to exchange information and enhance the quality of life for our Nursing Home Residents .
Oversight	N/A

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Nursing Homes

Overview	The Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA) licenses nursing facilities. A nursing facility (NF), or nursing home, provides 24-hour supervised nursing care, personal care, therapy, nutrition management, organized activities, social services, room, board, and laundry. The majority are privately-owned businesses. **Staff** The 2015 legislature passed Substitute House Bill 1274 that will require nursing homes beginning July 1, 2016 to provide a minimum of 3.4 hours per resident per day for direct care. Direct care is defined as registered nurses, licensed practical nurses and certified nursing assistants. Nursing assistants must meet the requirements in WAC 388-97-1660 (2). **Resident Rights** Rights of long-term care residents are found in Chapter 70.129 RCW, including the right to exercise reasonable control over life decisions in a safe, clean, comfortable, and homelike environment. They also have a right to choose to participate and engage in religious, political, civic, recreational, and other social activities that foster self-worth and enhance quality of life. **Choosing a Nursing Facility** It's important to thoroughly examine a facility's options to assure it is right for your needs. There are currently 230 nursing facilities in Washington state. These nursing facilities can be compared in a variety of ways, including the quality of care provided. One comparison tool is available on the national Medicare website at: http://www.medicare.gov/NursingHomeCompare/search.aspx, along with a Guide to Choosing a Nursing Home. Washington state has also launched a consumer-friendly website at: https://www.dshs.wa.gov/altsa/residential-care-services/long-term-care-residential-options to assist consumers in making informed decisions about long-term care Reports for surveys (inspections) completed January 1, 2013 thereafter and complaint investigations that result in a citation are available online upon completion.
Eligibility	Adults who meet certain medical criteria, typically with chronic care needs or disabilities that require 24-hour nursing care.
Authority	Chapter 388-97 WAC

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Budget	FY14 Expenditures: $8.5M
Rates	For people with limited income and resources, Medicaid uses both state and federal money to help pay for nursing facility care. The state bases payment rates on the care needs of the individual. Medicare pays for a minimal amount of nursing facility care. People who are veterans, or related to veterans, may qualify to have care paid for through the Veterans Administration. Each facility determines the amount that they will charge private pay residents. Private pay rates may differ.
Partners	Long-Term Care Ombuds Program Leading Age Washington Pioneer Network Washington Health Care Association
Oversight	NFs are inspected to ensure that they meet minimum care and safety requirements specified in law and rule. Facility licensing/certification surveys are one of numerous quality assurance activities that occur in NFs. On average, all nursing facilities are surveyed annually and this may include surveys conducted during both regular hours and off-hours. The on-site survey includes observation of resident activities and care, resident interviews, and review of resident records.

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Adult Family Homes

Overview	Adult Family Homes (AFHs) are regular residential homes licensed to care for two to six residents. The homes are private small businesses and provide the residents with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services. Room and board, care and services vary depending on provider qualifications and resident needs. Providers are required to have enough staffing to meet the needs of each resident. Residents may receive home health services or delegated nursing care while in the AFH. Staff who have credentials of Nursing Assistant Certified or Registered, or Certified Home Care Aides may receive training to perform some nursing tasks, such as glucometer testing or medication administration. The diversity of AFHs can satisfy different resident preferences. The AFH may be run by a family with children, a single person, or a couple. The AFH may also hire other employees. Some AFHs allow pets. In some homes, multiple languages may be spoken. AFH residents have the right to exercise reasonable control over life decisions. See http://www.altsa.dshs.wa.gov/Professional/afh/AFHinfo.htm for additional information on Resident Rights. In 2012, new law went into effect regarding long-term care worker training, which included increased training and certification requirements and national fingerprint-based background checks. With specialty training, providers can care for people with developmental disabilities, dementia, or mental illness. All AFH providers are required to respect resident rights and preferences, as well as provide a safe and healthy environment. All AFH providers and staff are required to report suspected abuse, neglect, or financial exploitation of residents.
Eligibility	AFHs are available to anyone over age 18 requiring support and supervision. Residents can pay privately or be funded through DSHS.
Authority	Chapter 388-76 WAC and Chapter 70.128 RCW.
Budget	FY14 Expenditures: $5.4M

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Rates	For the care of Medicaid residents, the Department pays contracted homes using a resident need-focused system based on seventeen levels of resident care and adjusted for geographic location. Each facility determines the amount that they will charge private pay residents. Private pay rates may differ.
Partners	Washington State Residential Care Council (WSRCC) AFHs United Disability Rights WA (DRW) Long Term Care Ombuds These provider advocacy groups provide member education and legislative representation.
Oversight	AFHs are required, by law, to be inspected at least every 18 months in addition to inspections associated with any complaint investigations. If a home is not in compliance with licensing requirements, DSHS enforcement actions ranging from civil fines to license revocation to referral of criminal allegations to law enforcement. Registered Nurse Complaint Investigators investigate provider practice complaints. Follow-up visits are made to ensure that regulation violations are corrected and do not continue.

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Assisted Living Facilities

Overview	An assisted living facility (ALF), formerly called a boarding home, is a community setting licensed by DSHS to care for seven or more residents. There are currently over 500 ALFs in WA state. The majority are privately-owned businesses. ALFs provide housing, basic services and assume general responsibility for the safety and well-being of the resident. The majority of residents pay for their care privately. ALFs allow residents to live an independent lifestyle in a community setting while receiving necessary services from staff. ALFs can vary in size and ownership from a family-operated 7-bed facility to a 150-bed facility operated by a large national corporation. Some ALFs provide intermittent nursing services or may serve residents with mental health needs, developmental disabilities, or dementia. ALFs that have a Medicaid contract with ALTSA provide one or more of the following service packages: **Assisted Living:** • Private apartments, with an emphasis on privacy, independence, and personal choice • Intermittent nursing services must be provided • Help with medication administration and personal care **Adult Residential Care (ARC)** • Medication assistance and personal care • Residents may need/receive limited supervision **Enhanced Adult Residential Care (EARC)** • Help with medication administration and personal care • No more than two people will share a room • Intermittent nursing care must be provided • Specialized dementia care – requires competitive bid & available funding The ALTSA website features a facility locator, which enables a search by county, zip code, and specialty care type. Also featured online are numerous publications, such as the Guide to Choosing Care (DSHS 22-270X), which includes practical tips on how to find a facility, questions you should ask, and steps that should be taken prior to placing a loved one in any setting. ALFs must ensure staff are trained to meet the needs of current residents. Newly-hired direct care workers (now called long-term care workers) must complete 75 hours of training, become certified as home care aides and complete 12 hours of continuing education per year.

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Eligibility Requirements	Individuals as characterized in WAC 388-78A-2050, typically ambulatory and not requiring frequent presence/evaluation of a registered nurse.
Authority	Chapter 388-78A WAC - Licensing Rules Chapter 388-110 WAC – Contracted Residential Care Services Chapter 388-112 WAC - Residential Long-Term Care Services Chapter 18.20 RCW - Licensing Statute Chapter 70.129 RCW - LTC Resident Rights Statute Chapter 74.34 RCW - Abuse of Vulnerable Adults
Budget	FY14 Expenditures: $4M
Rates	For the care of Medicaid residents, the Department pays contracted homes using a resident need-focused system based on seventeen levels of resident care and adjusted for geographic location. Each facility determines the amount that they will charge private pay residents. Private pay rates may differ.
Partners	Washington Health Care Association (WHCA) Leading Age State Long-Term Care Ombuds Program Department of Health Construction Review State Fire Marshal's Office
Oversight	All ALF staff are required, by law, to report suspected abuse or neglect of a resident. The Department offers training for these mandatory reporters. Specially-trained Department employees investigate complaints. Follow-up visits are made to ensure that regulatory violations do not continue. ALFs are required, by law, to be inspected at least every eighteen months, in addition to inspections associated with complaint investigations. If a home is not in compliance with licensing requirements, DSHS enforcement actions range from civil fines to license revocation to referral of criminal allegations to law enforcement.

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Washington State Department of Social & Health Services

Aging and Long-Term Support Administration

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Enhanced Services Facilities

Overview	The Washington State Legislature developed Enhanced Services Facilities (ESF) in order to provide a community placement option for individuals whose complicated personal care and behavioral challenges do not rise to a level that requires an institutional setting. Rather than extended and unnecessary stays in State Hospitals for residents who are not eligible for inpatient psychiatric treatment, residents who have been assessed as discharge ready can be placed in an ESF. The Legislature authorized the Aging and Long-Term Support Administration to develop this new category of licensed residential facilities under Chapter 70.97 RCW. ESFs will support moves from State Hospitals for people who are ready for discharge but would not otherwise have a community placement without this level of service. Enhanced Services Facilities use staffing ratios and behavioral and environmental interventions to serve individuals who are no longer receiving active treatment at a state psychiatric hospital. These facilities offer behavioral health, personal care services and nursing, a combination that is not generally provided in other licensed long-term care settings.
Eligibility Requirements	The general eligibility requirements for ESF residents are individuals who are at least eighteen years old and require daily care by, or under the supervision of, a mental health professional, chemical dependency professional, or nurse; or assistance with three or more activities of daily living. In addition to the requirements above, the individual must have a mental disorder and/or chemical dependency disorder, organic or traumatic brain injury, or cognitive impairment that results in symptoms or behaviors requiring supervision and facility services. Eligible individuals are those who do not meet the requirements for active treatment at a state hospital, but have not found appropriate placement in other community settings due to: self-endangering behaviors that are frequent or difficult to manage; intrusive behaviors that put residents or staff at risk; complex medication needs which include psychotropic medications; a history of, or likelihood of, unsuccessful placements in other licensed facilities; a history of frequent or protracted mental health hospitalizations; and/or a history of offenses against a person or felony offenses that created substantial damage to property.

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Authority	Facilities are regulated by Residential Care Services under RCW 70.97 and Chapter 388-107 WAC. Parts of Chapters 70.96A, 71.05, 10.77, 11.88 RCW and Chapter 388-112 WAC also apply to ESFs.
Budget	Regulation of this program is supported by state funds as well as facility licensing fees. ESF residents can be either Medicaid-supported or private pay.
Rates	The Department is authorized to establish license fees sufficient to cover the cost of licensing and enforcement of ESFs.
Partners	Western State Hospital Eastern State Hospital Department of Health Construction Review Services State Fire Marshal's Office Long-Term Care Ombuds Program
Oversight	Residential Care Services is authorized to license and regulate ESFs in accordance with Chapter 70.97 WAC and applicable WAC. Department of Health Construction Review Services reviews facilities for compliance with rules as they relate to structural safety prior to licensing and when providers make changes to the building. The State Fire Marshal's Office inspects each facility on an annual basis in accordance with the fire life safety code.

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Fact Sheet: Programs and Initiatives

Certified Community Residential Services & Support

Overview	**Supported living** means instruction, supports, and services provided to eligible clients by service providers, enabling clients to remain living in the community. These may include: (1) Supported living services; (2) Group home services; or (3) Services provided in a group training home. **Certified Group Home:** A community-based licensed and certified residential program where the provider, who contracts with the Department of Social & Health Services (DSHS), Developmental Disabilities Administration (DDA) to provide residential services, owns or leases the facility. The majority are privately-owned businesses. The homes vary in size, serving from 4 to 10 clients. Residential Care Services (RCS) licenses the home as either an Assisted Living Facility or an Adult Family Home, and certifies the group home through a separate process. This supports the provision of services at the levels required by the DDA contract. Room and board expenses are included in the rate paid by DDA and the clients participate toward their cost of care. DDA contracts with these providers to provide 24-hour supervision. **Certified Supported Living Services:** Residential services provided to DDA clients living in their own homes in the community, which are owned, rented, or leased by the clients or their legal representatives. DDA contracts with individuals and agencies to provide these services. Providers who offer these services are certified by RCS. Supported living offers instructions and supports which may vary from a few hours per month to 24 hours of one-on-one support per day. Clients pay for their own rent, food, and other personal expenses. DDA pays for residential services provided to clients under Department contract at the contracted rate. **Crisis Diversion Services:** DDA typically offers these services to clients who show a serious decline in mental functioning that puts them at risk of psychiatric hospitalization. **Community Protection Supported Living Services:** Provided to clients who meet the DDA community protection eligibility requirements. The program provides 24-hour supervision in a structured, therapeutic environment for persons with community protection issues, in order for the clients to live safely

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	and successfully in the community without re-offending, while minimizing the risk to public safety. **Group Training Homes:** 24-hour supervision, full-time care, treatment and training for adults with developmental disabilities. Operated on a non-profit basis by a person, association or corporation. Room and board expenses are included in the rate paid by DDA and the clients participate toward their cost of care. Also known as "Epton Act Homes", the Group Training Home model was created by legislation drafted in the early 1970's. There are only two Group Training Homes in the state.
Eligibility	N/A
Authority	Chapter 388-101 WAC
Budget	FY14 Expenditures: $900,000
Partners	Disability Rights WA The ARC of Washington Washington State Developmental Disabilities Council Community Residential Services Association Community Protection Providers' Association
Oversight	RCS performs regulatory compliance inspections at least every two years and investigates complaints related to provider practice concerns. Follow-up visits are made to ensure that regulatory violations have been corrected and the provider is back in compliance with WAC 388-101. If a report is substantiated, DSHS may take enforcement actions, such as termination of program certification.

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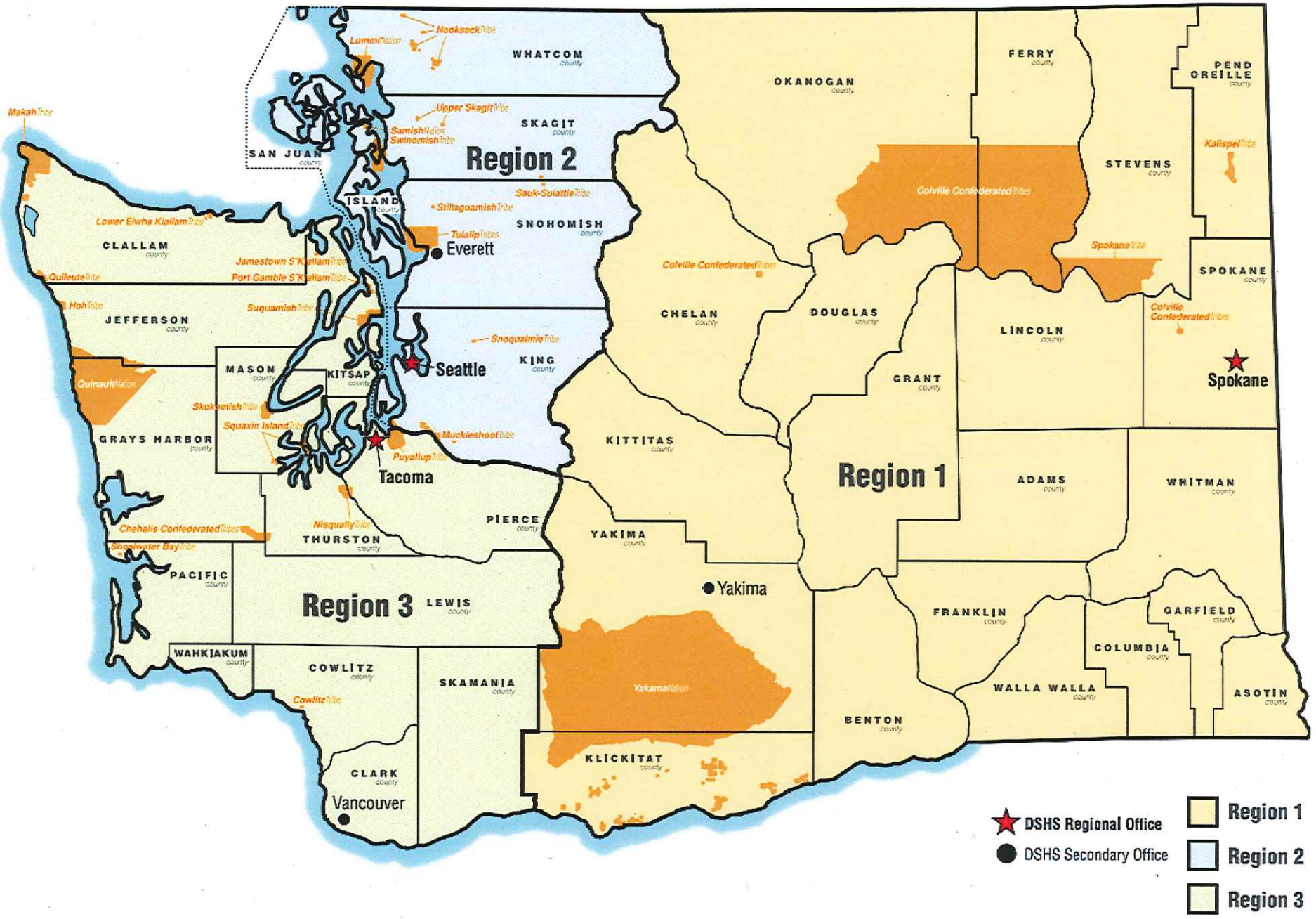
Fact Sheet: Programs and Initiatives

Complaint Resolution Unit Hotline 1-800-562-6078

Overview	The Complaint Resolution Unit (CRU) hotline **1-800-562-6078** receives and prioritizes complaints regarding provider practice, including suspected abuse or neglect in long-term care settings including adult family homes, assisted living facilities, nursing homes, intermediate care facilities for individuals with intellectual disabilities, enhanced services facilities and certified residential/supported living programs. The hotline is available 24 hours a day, seven days a week. Public callers may choose to speak to a live representative and remain anonymous. CRU staff return calls Monday through Friday between 8 a.m. and 4:30 p.m. **The CRU does not replace 911. If you, or someone you know, is experiencing a life-threatening emergency, call 911.**
Eligibility Requirements	The CRU hotline is available to the public and facilities. Facilities are mandated reporters and are required to report specific types of incidents.
Authority	Chapter 74.34 RCW
Budget	FY14 Expenditures: $1.6M
Partners	Depending on the nature and severity of the reported issue, reports may be referred to law enforcement, state professional licensing boards, Medicaid Fraud, Adult Protective Services or other state agencies. The Long-Term Care Ombuds advocates for the rights of vulnerable adults in long-term care facilities Ombuds help residents and their families to address concerns with facility owners and administrators. For an ombuds in your area, call 1-800-562-6028 or visit http://www.waombudsman.org/.
Oversight	Reports are documented in the CRU intake system, triaged, and may be assigned to the regional field office for investigation. When an investigation is conducted, RCS checks for compliance with specific regulations that govern licensed/certified providers. Regulations address many important areas, but not all issues that impact a resident are potential regulatory violations. If a violation is found, RCS may take enforcement action that ranges from imposing a monetary fine to revoking the license or certification.

Information Contact
Loida Baniqued, Headquarters Operations Office Chief
Division of Residential Care Services
Phone: (360) 725-2405 Email: loida.baniqued@dshs.wa.gov
2015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ASOTIN
BENTON
KLICKITAT
Nooksack Tribe
Lummi Nation
Upper Skagit Tribe
Samish Nation
Swinomish Tribe
Sauk-Suiattle Tribe
Stillaguamish Tribe
Tulalip Tribes
Makah Tribe
Lower Elwha Klallam Tribe
Quileute Tribe
Jamestown S'Klallam Tribe
Port Gamble S'Klallam Tribe
Hoh Tribe
Suquamish Tribe
Snoqualmie Tribe
Quinault Nation
Skokomish Tribe
Squaxin Island Tribe
Muckleshoot Tribe
Puyallup Tribe
Nisqually Tribe
Chehalis Confederated Tribes
Shoalwater Bay Tribe
Cowlitz Tribe
Colville Confederated Tribes
Spokane Tribe
Kalispel Tribe
Yakama Nation
DSHS Regional Office
DSHS Secondary Office
Region 1
Region 2
Region 3

Overview of the Washington State Long Term Care Ombudsman Program

Prepared by Patricia Hunter October 16, 2015 (LTCOP Director)

The Washington State Long-Term Care Ombudsman Program (LTCOP) has served under federal and state law since 1972 as an advocate and provider of direct referral and assistance to residents in long-term care facilities: nursing homes, assisted living facilities, and adult family homes. The Program also serves residents who live in Washington State's Veterans Homes and in the nursing home sections of Residential Habilitation Centers (RHCs). Initially the LTCOP was housed within the Washington State Department of Health and Human Services, but in 1989 in order to provide the Ombuds and the Program greater independence, the State Legislature removed the program from DSHS and located it in a private, non-profit organization.

The Ombudsman Program was initiated in 1972 as a Public Health Service demonstration project in response to concerns about poor quality of care in nursing homes. IN 1978 Congress amended the Older Americans Act to require each state to develop a Long-Term Care Ombudsman Program. The Act was reauthorized in 1992, and again in 2000, each time with provision to continue the program.

The role of the LTCOP is to assist residents and advocate for improved quality of life and care. This is done through providing information and education materials to residents (and their families) about their rights and long-term care services, to identify and resolve complaints made by or on behalf of residents, and to intervene in problem situations on behalf of consumers, residents, and their families involving the long term care delivery system. The authority of the LTCOP is set forth in RCW 43.190 and WAC 365-18.

The Ombuds is required to investigate complaints brought by or on behalf of LTC residents, including complaints relating to the appointment and activities of guardians. 42 USCA § 3058g. The Ombuds must also represent the interests of LTC residents before governmental agencies and seek remedies to protect them. 42 USCA § 3058g, RCW 43.190.065. More broadly, the LTC Ombuds is required to provide analysis, recommend changes, facilitate public comment, and monitor the implementation of federal and state laws and government actions that affect LTC residents. 42 USC § 3058g(a)(3), RCW 43.190.065.

CMS.gov
Centers for Medicare & Medicaid Services

Nursing Homes

This page provides basic information about being certified as a Medicare and/or Medicaid nursing home provider and includes links to applicable laws, regulations, and compliance information. Below in the downloads section, we also provide you related nursing home reports, compendia, and the list of special focus facilities (i.e., nursing homes with a record of poor survey (inspection) performance on which CMS focuses extra attention).

Skilled nursing facilities (SNFs) and nursing facilities (NFs) are required to be in compliance with the requirements in 42 CFR Part 483, Subpart B, to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, a state surveyor completes at least a Life Safety Code (LSC) survey, and a Standard Survey.

SNF/NF surveys are not announced to the facility. States conduct standard surveys and complete them on consecutive workdays, whenever possible. They may be conducted at any time including weekends, 24 hours a day. When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the entrance conference and initial tour should is modified in recognition of the residents' activity (e.g., sleep, religious services) and types and numbers of staff available upon entry.

The State has the responsibility for certifying a skilled nursing facility's or nursing facility's compliance or noncompliance, except in the case of State-operated facilities. However, the State's certification for a skilled nursing facility is subject to CMS' approval. "Certification of compliance" means that a facility's compliance with Federal participation requirements is ascertained. In addition to certifying a facility's compliance or noncompliance, the State recommends appropriate enforcement actions to the State Medicaid agency for Medicaid and to the regional office for Medicare.

The CMS regional office determines a facility's eligibility to participate in the Medicare program based on the State's certification of compliance and a facility's compliance with civil rights requirements.

The following entities are responsible for surveying and certifying a skilled nursing facility's or nursing facility's compliance or noncompliance with Federal requirements:

- **State-Operated Skilled Nursing Facilities or Nursing Facilities or State-Operated Dually Participating Facilities** - The State conducts the survey, but the regional office certifies compliance or noncompliance and determines whether a facility will participate in the Medicare or Medicaid programs.
- **Non-State Operated Skilled Nursing Facilities** - The State conducts the survey and certifies compliance or noncompliance, and the regional office determines whether a facility is eligible to participate in the Medicare program.
- **Non-State Operated Nursing Facilities** - The State conducts the survey and certifies compliance or noncompliance. The State's certification is final. The State Medicaid agency determines whether a facility is eligible to participate in the Medicaid program.
- **Non-State Operated Dually Participating Facilities (Skilled Nursing Facilities/Nursing Facilities)** - The State conducts the survey and certifies compliance or noncompliance. The State's certification of compliance or noncompliance is communicated to the State Medicaid agency for the nursing facility and to the regional office for the skilled nursing facility. In the case where the State and the regional office disagree with the certification of compliance or noncompliance, there are certain rules to resolve such disagreements.

Other Nursing Home related data and reports can be found in the downloads section below

New Posting - Evaluation of the Quality Indicator Survey (QIS)

The Executive Summary of the Evaluation Report of the Quality Indicator Survey (QIS) is now available for download. The QIS evaluation was funded early in the 5-State QIS pilot, and was designed to answer questions about accuracy, documentation, changes in the number and type of deficiencies, and whether the QIS process is more efficient. Improved consistency is inherently embedded into QIS processes, so this was not evaluated. The Study instead assessed whether the QIS also had beneficial effects on other aspects of the survey process, such as improving the accuracy of citations. Since the evaluation did not find improved accuracy, we conclude that non-QIS factors, including (a) survey guidance clarification, (b) training of surveyors, and (c) surveyor supervision are prudent approaches to improvement of accuracy. CMS continues to issue improved surveyor guidance as well as to strengthen surveyor training. We also concluded that future QIS development efforts should concentrate on building upon the QIS strengths relative to consistency improvement, and giving supervisors more tools to assess performance of surveyor teams.

See below for:

- Evaluation of the Quality Indicator Survey: Executive Summary
- Special Focus Facility Initiative and List - **updated October 15, 2015**

- 2012 Nursing Home Action Plan
- 2013 Nursing Home Data Compendium
- 2007 Study of Paid Feeding Assistant Programs

Downloads

Evaluation of the Quality Indicator Survey: Executive Summary [PDF, 122KB]
Special Focus Facility Background Info and List - Updated 10/15/15 [PDF, 76KB]
2012 Nursing Home Action Plan [PDF, 544KB]
Nursing Home Data Compendium 2013 [PDF, 7MB]
Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities [PDF, 891KB]

Related Links

Nursing Homes
Nursing Home Quality Initiative
Social Security Act Section 1819
Study of Paid Feeding Assistant Programs - Full Report (PDF, 1.4 MB)
Social Security Act Section 1919
42 CFR 483.350 - 483.376

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CMS.gov A federal government website managed by the Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

CMS.gov
Centers for Medicare & Medicaid Services

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

This page provides basic information about being certified as a Medicare and/or Medicaid Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) provider and includes links to applicable laws, regulations, and compliance information.

The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify for Medicaid assistance financially.

Since the implementation of the current regulations in 1988, there has been a major shift in thinking in the field of developmental disabilities. Emphasis is now on people living in their own homes, controlling their own lives and being an integral part of their home community. CMS recognized that the current 1988 ICF/IID regulations and survey process needed to be updated and therefore, undertook several major tasks in this program. This web site includes current CMS initiatives for the ICF/IID program.

Downloads

ICFIID Background [PDF, 31KB]
ICFIID Glossary [PDF, 42KB]
ICFIID Trends [PDF, 30KB]
Chapter 1 - Program Background and Responsibilities [PDF, 136KB]
Chapter 2 - The Certification Process [PDF, 1MB]

Related Links

Section 1905(a)(16) of the Social Security Act
Section 1902(a)(33) and (i)(1) of the Social Security Act
Section 1922 of the Social Security Act
Related Regulation - 42 CFR 435.1008 - 435.1009
42 CFR 440.150 and 440.220
42 CFR 442.118-119
42 CFR 483.350 - 483.376
42 CFR 498.3-5
Survey & Certification - Enforcement

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Disability Rights WASHINGTON
Washington's protection and advocacy system

Published on *Disability Rights Washington* (http://www.disabilityrightswa.org)

What is DRW?

Disability Rights Washington (DRW) is a private, non-profit organization that protects the rights of people with disabilities statewide.

Our mission is to advance the dignity, equality, and self-determination of people with disabilities. We work to pursue justice on matters related to human and legal rights. We provide free advocacy services to people with disabilities.

Contact us for:

- Disability rights information and referrals
- Problem solving strategies for disability issues
- Community education and training
- Legal services for disability discrimination or violation of rights.

We focus our legal resources on major cases which will improve service systems for people with disabilities. We exist because society and service systems are not always fair or responsive to people with disabilities. We work for change in policies, laws and systems that promote:

- Freedom from abuse and neglect
- Legal rights and responsibilities
- Adequately funded supports and services
- Communities that involve everyone

DRW is governed by a Board of Directors with help from our Advisory Councils. These groups are made up of people with disabilities, family members and others who have an interest in disability rights.

If you would like more information, please contact us.

The following federal funding partners shared in the cost of producing this material: the Administration on Intellectual and Developmental Disabilities, AIDD (1501WAPADD); the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, SAMHSA (15SMP05397); and the Rehabilitation Services Administration, RSA (H240A140048). These contents are the sole responsibility of Disability Rights Washington and do not necessarily represent the official views of AIDD, SAMHSA or RSA.

This information is current as of: 02/2015

This information sheet is a service of Disability Rights Washington (DRW). It provides general information as a public service only, and is not legal advice. If you need legal advice, you should contact an attorney. You do not have an attorney-client relationship with DRW. If you would like more information about this topic or would like to receive this information sheet in an alternative format, such as large print or Braille, call DRW at (800) 562-2702.

Always advocate in a timely manner. Please be aware that there are certain time limits or deadlines to file a complaint, a lawsuit, or take legal action.

DRW cannot guarantee that any individual or organization included in this material will represent or assist you. DRW also cannot guarantee the quality of this individual's or organization's representation.

Disability Rights Washington
315 Fifth Avenue South, Suite 850
Seattle, WA 98104
T: 206-324-1521 or 800-562-2702
Fax: 206-957-0729
Email: info@dr-wa.org
Website: DisabilityRightsWA.org

Interpreters Available

DRW is a member of the National Disability Rights Network.
A substantial portion of the DRW budget is federally funded.

Source URL: http://www.disabilityrightswa.org/what-drw

Links:
[1] http://www.disabilityrightswa.org/tools-help-you/about-drw

Disability Rights of Washington's Role

Prepared by David Lord, DRW October 20, 2015

Disability Rights Washington (DRW) is a private non-profit organization that protects the rights of people with disabilities statewide. Our mission is to advance the dignity, equality, and self-determination of people with disabilities. We work to pursue justice on matters related to human and legal rights.

We provide free services to people with disabilities. We serve people with all disabilities. Our constituents contact us for:

- disability rights information;
- technical assistance for disability issues;
- general information about legal rights;
- strategies about how to become a stronger self-advocate;
- information sheets on a wide range of subjects to empower individuals with disabilities to better advocate for themselves;
- community education and training; and
- legal services for disability rights violations.

We focus our legal resources on systemic cases which will improve service systems for people with disabilities.

We exist because society and service systems are not always fair or responsive to people with disabilities. We work for change in policies, laws, and systems that promote:

- freedom from abuse and neglect;
- legal rights;
- adequately funded, appropriate supports and services; and
- communities that involve everyone.

DRW is governed by a Board of Directors with help from our Advisory Councils. These groups are made up of people with disabilities, family members and others who have an interest in disability rights.

P&A access enforcement

Protection and advocacy is commonly referred to as "P&A". Disability Rights Washington is the non-profit agency designated as the "P&A" for Washington state. People with disabilities have access to protection and advocacy services, which are defined in federal law. The protection and advocacy system enforces their rights using its authority.

Disability Rights Washington, Washington's designated protection and advocacy agency, enforces its access authority through technical assistance, individual advocacy and publications and/or videos.

Congress has given DRW - and all other protection and advocacy (P&A) agencies - some special authority to meet with individuals with disabilities in almost all living environments, including (but not limited to) individual and family homes, group homes, supported living homes, rehabilitation facilities, community and state hospitals, nursing homes and other institutions and long-term care facilities, and even jails and prisons. Protection and advocacy agencies have broad authority to monitor these living environments, and can investigate wherever the P&A finds probable cause to believe that there is abuse and neglect occurring. The standard for probable cause is lower than that used in criminal justice system.

Subject to available resources, DRW maintains a presence in facilities that serve people with disabilities. In facilities, DRW monitors, investigates and attempt to remedy adverse conditions.

For more on P&A mandate and authority: http://www.ndrn.org/about/paacap-network.html

While DRW seeks to resolve concerns at the lowest level, DRW has the authority to bring law suits on behalf of its constituents in order to enforce their rights. DRW has been very successful in recent years in the use of class action lawsuits and other systemic litigation to address rights violations.

Relationship to Long-Term Care Ombuds Program:

DRW maintains a cooperative relationship with the Long-Term Care Ombuds (LTCOP). The LTCOP is also federally mandated, with authority to monitor and advocate on behalf of residents of long-term care facilities. Because most residents of facilities are people with disabilities, the authority of the LTCOP and DRW overlap. Staff from DRW and the LTCOP meet frequently, and seek to ensure that their work is coordinated so it is effective and efficient, and that their goals are consistent with the choices and preferences of their constituency.

Freedom from abuse/neglect

Among the most fundamental of human rights is the right to be free from abuse or neglect. The protection and advocacy network, of which DRW is a part, was created by a federal law enacted on the heels of a 1972 investigative report of the Willowbrook Institution. In this facility, made for 4000, 6000 people with disabilities were warehoused, in tattered or no clothes, with little food or staff, and subject to rampant sexual and physical abuse. Since then, DRW, and its counterparts in all US states and territories, are charged with improving abuse response systems and responding to the abuse and neglect of people with disabilities.

Unfortunately, abuse happens everywhere, in community and facility settings. DRW investigates and responds to complaints of harm in state and private facilities, in hospitals and supported living environments. DRW's collaborative advocacy with sexual assault and domestic violence advocates, and law enforcement, is aimed at making systems more accessible. DRW works extensively with the state to advance an abuse response system that appropriately addresses the needs of people with disabilities.

Resources

DRW receives funding to accomplish its mandate from the federal government, and also accesses some private funding through grants and donations. However, DRW's ability to provided advocacy to address rights violations is constrained by funding limitations In addition to monitoring facilities and addressing abuse and neglect, DRW devotes considerable resource to advocating for inclusive educational programs, financial entitlements, healthcare, accessible housing and productive employment opportunities. DRW apportions its resources based on a structured priority-setting process.

(10)(f)(ii) From the provider perspective, and the perspective of a state agency, an overview of the process for reviewing and responding to findings by Residential Care Services and Centers for Medicare and Medicaid Services;

Overview of Residential Care Services' Process for Reviewing and Responding to Findings

Residential Care Services (RCS) is responsible for the licensing, certification and oversight of adult family homes, assisted living facilities, enhanced services facilities, nursing homes, certified residential community services (supported living), and Intermediate Care Facilities for Individuals with Intellectual Disabilities. Oversight is done through inspections and investigations with law and rule enforcement authority. RCS conducts provider practice investigations in all of our settings. Licensors/surveyors investigate if there is a system break down in quality of care and services provided. Complaints about safety, medication, food, resident rights, and quality of life are some examples of provider practice investigations. RCW 74.39A.060

Below is a high-level overview of each licensed/certified setting definition, our role in inspections and investigations and the enforcement actions RCS is authorized to take if a provider is not in compliance with the regulations.

Adult Family Home (AFH) means a residential home in which a person or an entity is licensed to provide personal care, special care, and room and board to more than one but not more than six adults who are not related by blood or marriage to a licensed operator, resident manager, or caregiver, who resides in the home. Adult family homes may also be designated as a specialty home (on their AFH license) in one or more of the following three categories: Developmental Disability, Mental Illness, and Dementia if they meet all certification and training requirements. Chapter 388-76 WAC

- **Inspections and investigations:**
  - Initial licensing Inspections
  - Annual Inspections (at least every 18 months with an annual average of 15 months)
  - Revisit Inspection
  - Complaint Investigations
  - Monitoring Visits (follow-up to sanctions)
- **Enforcement actions**:
  - Denial of an application for a license;
  - Impose reasonable conditions on a license;
  - Impose civil penalties;
  - Order stop placement; and/or
  - Suspension or revocation of license

Assisted Living Facility (ALF) means any home or other institution, however named, which is advertised, announced, or maintained for the express or implied purpose of providing housing, basic services, and assuming general responsibility for the safety and well-being of the residents, and may also provide domiciliary care, consistent with Chapter 388-78A WAC to seven or more residents. ALFs do not include group training

homes, independent senior living, or continuing care retirement communities which are subsidized by HUD. Chapter 388-78A WAC

- **Inspections and investigations:**
  - Initial licensing/Preoccupancy Inspections
  - Annual Inspections (at least every 18 months with an annual average of 15 months)
  - Revisit Inspection
  - Complaint Investigations
- **Enforcement actions**:
  - Deny, suspend, revoke, refuse to renew a license;
  - Suspend admissions to a facility;
  - Suspend admissions of a specific category of residents;
  - Impose conditions on a license;
  - Impose civil penalties of not more than $100 per day per violation;
  - Impose civil penalties up to $3000 per day per violation for interference, coercion, discrimination and/or reprisal by a facility.

Enhanced Services Facility (ESF) means a facility that provides treatment and services to persons for whom acute inpatient treatment is not medically necessary and who have been determined by the department to be inappropriate for placement in other licensed facilities due to the complex needs that result in behavioral and security issues. Chapter 388-107 WAC

- **Inspections and investigations:**
  - Initial licensing/Preoccupancy Inspections
  - Annual Inspection (at least once every 18 months)
  - Complaint investigations
- **Enforcement actions:**
  - Deny, suspend, revoke, refuse to renew a license;
  - Suspend, revoke, or refuse to issue or renew a license;
  - Order stop placement; or
  - Assess civil monetary penalties.

Nursing Home (NH) means any home, place or institution which operates or maintains facilities providing convalescent or chronic care, or both, for a period in excess of twenty-four consecutive hours for three or more patients not related by blood or marriage to the operator, who by reason of illness or infirmity, are unable properly to care for themselves. Skilled Nursing Facility (SNF) or "medicare-certified skilled nursing facility" means a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to medicare recipients under Section 1819(a) of the federal Social Security Act. Chapter 388-97 WAC ; State Operations Manual, CH 7

- **Inspections and investigations:**
  - Initial licensing/Preoccupancy

- Annual Inspections (at least every 15 months with an average 12 months)
- Revisit Inspection
- Complaint Investigations

- **Enforcement actions:**
  - Stop placement;
  - Immediate closure of a nursing home, emergency transfer of residents or both;
  - Civil fines;
  - Appoint temporary management;
  - Petition the court for appointment of a receiver in accordance with RCW 18.51.410;
  - License denial, revocation, suspension or nonrenewal;
  - Denial of payment for new medicaid admissions;
  - Termination of the medicaid provider agreement (contract);
  - Department on-site monitoring as defined under WAC 388-97-0001; and
  - Reasonable conditions on a license
  - For a SNF and/or a NF, RCS may also refer the facility to the Centers for Medicare and Medicaid Services (CMS) to impose remedies at the federal level.

Certified Community Residential Services and Supports (CCRSS) –also referred to as Supported Living-means instruction, supports, and services delivered by service providers to clients living in homes that are owned, rented, or leased by the client or their legal representative. Chapter 388-101 WAC

- **Recertification and investigation:**
  - On-site certification evaluation (anytime or at least every two years)
  - Complaint investigation
- **Enforcement actions:** (effective January 2016 in relation to HB1307)
  - Revoke the certification and terminate the residential services contract.

  Additionally for community protection programs:
    - Impose conditions on a service provider's certification status;
    - Suspend department referrals to the service provider;
    - Impose civil penalties of not more than $150 per day; and
    - Impose a separate violation each day during which the same or similar action or inaction occurs.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) are residential settings designed to meet the needs of four or more individuals with intellectual disabilities who require twenty-four hour active treatment services. Many of the individuals have complicated physical or behavioral needs. All must qualify for Medicaid assistance financially. ICF/IID facilities are governed by both federal certification and state licensure rules. ICF/IID 42 CFR Part 442, Subpart C

- **Recertifications and investigations:**
  - Annual recertification (every 9-15 months with 12 month average)
  - Post recertification visits (as needed in relation to citations)

- Complaint investigations
- Post complaint investigations (as needed in relation to citations)

- **Enforcement actions:**
  - Termination of provider agreement
  - Denial of payment for all new admissions
  - Directed Plan of Correction
  - Directed In-service Training
  - State Monitoring
  - Additional actions could include those listed in specific program rules for ICF/IID facilities that also have an Assisted Living Facility or Nursing Home license.

(10)(f)(iii) A description of the process for notifying the Office of the Governor and the Legislature when problems with quality of care, client safety and well-being, or staff safety arise within community or institutional settings;

- Department of Social and Health Services (DSHS) Administrative Policy (AP) 9.01 Incident Reporting.

- As incidents occur or arise the department contacts the Office of the Governor, or Legislature, based upon the impending concern. There is no established protocol.

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

Administrative Policy No 9.01

Subject: Incident Reporting

Information contact: Chief Risk Officer
MS 45020
Tel: (360) 902-7794

Authorizing source:
Administrative Policy 2.08 – Media Relations Policy
Administrative Policy 5.01 - Privacy Policy -- Safeguarding Confidential Information
Administrative Policy 8.02 – Client Abuse
Administrative Policy 9.03 – Administrative Review - Death of Residential Clients
Administrative Policy 9.11 – Emergency Management
Administrative Policy 18.62 – Allegation of Employee Criminal Activity
Administrative Policy 16.10 – Reporting Known or Suspected Loss of Public Funds or Assets to the State Auditor's Office.

Effective date: September 15, 1990

Revised: October 27, 2011

Approved by: Patricia K Lashway
Senior Director, Policy and External Relations

Sunset review date: October 27, 2015

Purpose

This policy establishes a uniform system for reporting incidents within the Department of Social and Health Services (DSHS).

Scope

This policy applies to all Department of Social and Health Services (DSHS) organizational units. It outlines general requirements for agency incident reporting.

Other DSHS policies contain specific reporting requirements for incidents involving contact with the media, client abuse, breach of client confidentiality, loss or compromise of confidential information, loss of public funds or assets, allegations of employee criminal activity, death of residential clients and emergency management.

Definitions

Major Incident means a matter requiring immediate attention of the Secretary, the appropriate Assistant Secretary, the Chief Risk Officer and the Senior Director of Communications. This includes any situation involving harm or damage, or the threat of harm or damage to:

1. People
2. Property
3. Function of systems or security of information
4. Organizational reputation

Examples include:

- **Death.** The death of any person under unusual, suspicious or violent circumstances in a DSHS facility or involving a DSHS related activity.
- **Significant Injury.** Any injury that results from a work-related or service-related incident that requires professional medical attention beyond diagnostic and/or emergency room care.
- **Escape/Walk-away.** A person at high risk to self or others who is under the supervision and custody of a DSHS operated or contracted facility who leaves the physical confinement or grounds of that facility or the supervision and custody of DSHS staff while off grounds, without express permission.
- **Major Disruption of a DSHS Service.**
- **Major violence or threat of significant violence** that involves a DSHS employee, client or other person at a DSHS location, activity or program.
- **Confidential Data Loss.** Potentially compromise the security or privacy of confidential information held by DSHS or its contractors that poses a significant risk of financial, reputational or other harm effecting over 500 clients.
- **Property loss or damage** valued in excess of $100,000.
- **Potential compromise of agency reputation.**

Policy

To safeguard the health and safety of clients and employees and to protect the interests of the Department and the State, DSHS incidents that meet the definition in this policy must be fully and rapidly reported.

A. Administration-specific Policy and Protocol

1. Each DSHS administration or administrative subdivision must have a written incident policy which includes:
   - Responding to incidents at the time of the event.
   - Reporting incidents.
   - Reviewing incidents.

2. Each DSHS administration must ensure employees are trained as appropriate regarding their specific incident reporting requirements.

B. Reporting Requirements

1. DSHS employees must report all incidents following their administration's reporting requirements.

2. DSHS Assistant Secretaries or designees must report a major incident, at the earliest reasonable opportunity, to the Office of the Secretary, the Chief of Staff, the Director of Communications, the Chief Risk Officer, and the Director, Office of Emergency Management.

3. All other Department, Federal and State of Washington reporting requirements must be met.

Resource

Major Incident Reporting, Administration and Division Guidelines:
http://one.dshs.wa.lcl/FS/Loss/Management/Pages/CIRT.aspx

Washington State Department of Social and Health Services

Transforming Lives

Aging and Long-Term Support Administration
Incident Reporting Process

This process outlines incident reporting policy and procedures for the Aging and Long-Term Support Administration as authorized by DSHS Administrative Policy 9.01, Incident Reporting. Aging and Long-Term Support Administration staff are trained and expected to adhere to DSHS Administrative Policy 9.01.

Major Incident means a matter requiring immediate attention of the Secretary, the appropriate Assistant Secretary, the Chief Risk Officer and the Senior Director of Communications. This includes any situation involving harm or damage, or the threat of harm or damage to:

- People
- Property
- Function of systems or security of information
- Organizational reputation

Procedure:

1. Upon notification of a major incident, staff must complete an Incident Report and submit to their Division Director for review.
2. The Division Director shall review and respond appropriately to resolve incidents as quickly as possible.
3. All major incident reports are due to the Assistant Secretary's Communications Office no later than 24 hours from the time of notification of a major incident.
4. The Assistant Secretary reviews major incident reports and at the Assistant Secretary's discretion, incident reports are submitted to the DSHS Secretary by the Assistant Secretary's Communications Office.
5. The Secretary or Assistant Secretary may share information with other partners including the legislature and legislative committees as necessary. Public disclosure and HIPAA regulations are applied in accordance with federal and state law to prevent disclosure of confidential information outside of the Department.

Training on how to appropriately write and submit incident reports is provided regularly by the ALTSA Assistant Secretary's Communications Office. For additional information, please contact, Renee Fenton at (360) 725-2270 or by email at FentoRC@dshs.wa.gov.

Washington State Department of Social & Health Services
Transforming lives

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

Narrative Summary

TOP 5 RCS Licensed | Certified Provider

Areas of Provider Non-compliance and Deficiencies

Non-compliance causes – Survey and inspections reveal the following causes of non-compliance as:

1. Lack of understanding, knowledge and experience in operating a business.
2. Lack of effective quality assurance and monitoring activities by facilities to ensure continued compliance with the federal and state regulations.
3. Turnover of administrative personnel and direct caregivers.
4. Lack of resources to provide the care and services of residents with higher acuity needs.
5. Ongoing change of ownerships leading to inconsistent and fractured implementation of quality assurance systems.

Recommended Solution:

One recommended solution is to re-establish Quality Assurance Nurse (QAN) monitoring programs in nursing homes and Quality Improvement Consultant nurse programs in assisted living facilities. Creation of similar programs in adult family homes, supported living settings, intermediate care facilities, and enhanced services facilities can improve quality and education of providers.

Adult Family Home	FY2010	FY2011	FY2012	FY 2013	FY2014
Chapter Description	Count of Total	Count of Total	Count of Total	Count of Total	Count of Total
Abuse	320	528	183	307	163
Abuse, punishment, seclusion			1		1
Administration-General	909	1533	548	976	425
Adult family home provider, resident manager	1				1
Adult family homes	1				1
Advocacy, access, and visitation rights	1				
Basic Training	56	13	6	14	37
Care and Services	744	718	335	637	230
Competency Training				2	
Continuing Education	519	411	3	352	12
CPR and First Aid Training	185	147	42	155	15
Criminal History Background Check	771	662	127	590	98
Curriculum Approval				1	
Department authority to take actions in response to noncompliance			3	3	
Disaster and Emergency Prepardness	490	526	1	396	2
Disclosure of fees and notice requirements	1	1	4	3	1
Disclosure, transfer, and discharge requirements	8	15			14
Facility's policy on accepting medicaid as a payment source	26	1		1	
Fire Drill Plan for Emergency Evacuation	517	566	28	448	14
Fire Protection	401	328	20	314	18
Food Services	158	120	34	118	32
Granting or Denying a License	8	36	8	24	7
Health Care Decision Making	174	108	26	161	29
Infection Control and Communicable Disease	48	59	14	76	2
Inspections--Complaint Investigations--Monitoring Visits	41	13	24	27	21
Instructor Approval				2	
License	186	176	156	226	159
License		1			
License Application	36	87	32	4	23
Long-term Caregiver training				7	
Management Agreements				2	
Medical Devices and Restraints	507	356	44	451	22
Modified Basic Training	5	7	1	2	
Negotiated Care Plan	1658	1671	288	1698	276

Notice of rights and services	1	6	2	14	7
Nurse Delegation Core Training	14	28	2	15	
Orientation	430	298	23	210	46
Personal property				1	
Physical Plant Basic Requirements	1448	1483	155	1417	101
Privacy and confidentiality of personal and medical records			1	1	
Protection of resident's funds	1	1	5	1	5
Qualifications of Individuals Providing Care and Services	541	470	121	626	99
Quality of Life		97	83	117	38
Quality of Life	104	1		4	
Remedies	51	44	44	71	40
Required training and continuing education	2	1			
Resident Advocate Access	1	1			
Resident Asssessment	632	554	121	466	55
Resident Medications	2739	3124	532	2753	323
Resident Protection Program				1	
Resident Records	368	391	79	429	41
Resident Rights	1216	2499	386	2502	400
Residential Care Administrator Training	1	4		3	
Rights are minimal					1
Specialty Care	5	25	7	32	
Specialty Training	103	310	86	223	69
Toll-free telephone number for complaints				2	
Tuberculosis Screening	632	527	26	371	28
(blank)					
Grand Total	**16058**	**17947**	**3601**	**16256**	**2856**

Assisted Living Facility	FY2010	FY2011	FY2012	FY 2013	FY2014
Chapter Description	Count of Total	Count of Total	Count of Total	Count of Total	Count of Total
Abuse, punishment, seclusion	2	4	2	5	2
Administration-Administrator	56	36	54	23	49
Administration-Building	282	286	380	373	359
Administration-Disclosure	6	7	9	5	2
Administration-Infection Control	46	51	59	133	88
Administration-Inspections, Enforcement Remedies, and Appeals	12	5	40	17	18
Administration-Licensing	58	117	169	89	100
Administration-Management Agreements		1			
Administration-Policies and Procedures	112	130	103	82	90
Administration-Reporting Requirements	167	167	177	171	190
Administration-Resident Rights	199	261	221	234	215
Administration-Safety and Disaster Preparedness	549	501	487	455	386
Administration-Specialized Training	12	17	13	19	17
Administration-Staff	628	551	607	581	570
Adult Day Services	7	1			
Advocacy, access, and visitation rights	1	3	2	1	2
All Contracted Residential Care Services	5	11	7	6	3
Applicability	6	1118	4	1	5
Assessment and Monitoring	909	13	857	656	666
Assistance with activities of daily living					1
Assisted Living Services	7	24	3	6	4
Basic Training	34	38	32	12	15
Boarding Home Services	27	19	35	13	9
Continuing Education	15	40	35	9	92
Correction of violation/deficiency				1	
CPR and First Aid Training	41	1	50	55	46
Curriculum Approval					2
Definitions					1
Dementia Care	22	48	11	28	17
Department response to noncompliance or violations					1
Disclosure of fees and notice requirements	10	21	9	8	16
Disclosure, transfer, and discharge requirements	115	106	83	38	125
Enhanced Adult Residential Care	19	7	5	7	5
Examination of survey or inspection results	3	1	3	5	5

Exercise of rights	2	5	7	8	7
Facility's policy on accepting medicaid as a payment source			1	3	10
Food	183	239	294	251	276
Food handling			2	1	
General	23	1	23	12	15
General responsibility for each resident					2
Grievances	10	22	16	20	21
Home-based Training			2		3
Instructor Approval			1	1	1
Intent—Basic rights	3	22	1	3	1
Intermittent Nursing Services	194	5	193	228	172
Issuance of food worker cards -- Fees				1	1
Mail and telephone	1	150	4	1	1
Management and personnel				2	1
Medications	416	1	421	436	407
Modified Basic Training	14	1	9	3	
Negotiated Service Agreement	459	394	529	459	462
Notice of rights and services	15	6	20	21	23
Nurse Delegation Core Training			2		3
Orientation	149	516	65	15	17
Personal property	1	14			1
Privacy and confidentiality of personal and medical records	5	9	7	6	4
Protection of resident's funds	4	84	1	1	
Public health labeling				1	
Purpose and authority				1	
Quality of life	67	1	75	70	54
Resident Records	122	5	153	132	106
Resident rights	1	3	1		
Residential Care Administrator Training	5	100	5	3	
Respite	5	137		2	2
Restraints	3	2	1		
Restricted Egress	9	6	12	10	13
Rules, regulations, and standards				1	
Specialty Training	62	14	79	71	77
Validity and form of food worker cards			1	22	3
Waiver of liability and resident rights limited	1	53	3	4	7
Water, plumbing, and waste	1	7			

Withdrawal from medicaid program	11	5	16	12	14
Grand Total	**5116**	**5387**	**5401**	**4834**	**4805**

Nursing Home	FY2010	FY2011	FY2012	FY 2013	FY2014
Chapter Description	Count of Total	Count of Total	Count of Total	Count of Total	Count of Total
ACCESS TO STATIONERY/POSTAGE/PENS, ETC		1			
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	55	25	4	16	24
ADEQUATE & COMFORTABLE LIGHTING LEVELS	1	1	3		1
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	2	1			
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	58	44	55	27	38
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	1	2	14		1
ADMINISTRATION	3	5	18	1	
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE				2	
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	1	1		2	3
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	2		14	1	
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	28	6	11	6	18
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	1	1	41		2
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	1	1			
BEDROOMS ASSURE FULL VISUAL PRIVACY	1	1	68		2
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR		1			
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	12	9	2	11	11
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	1		1		5
CLEAN BED/BATH LINENS IN GOOD CONDITION		1	48		1
COMFORTABLE & SAFE TEMPERATURE LEVELS	4	2	23	4	3
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	3	4	24		1
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	9	3	9		3
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	1				
COMPREHENSIVE ASSESSMENTS	58	82	40	47	35
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	3	4	3		3
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	1	1	4	1	1
DEVELOP COMPREHENSIVE CARE PLANS	75	97	85	82	81
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	60	66	31	40	33
DIGNITY AND RESPECT OF INDIVIDUALITY	64	79	65	87	78
DISPOSE GARBAGE & REFUSE PROPERLY	4	3		1	2
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	9				1
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	27	49	9	59	61
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	82	101	23	86	97
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	8	24	2	17	9
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	11	13	5	9	8
EMERGENCY ELECTRICAL POWER SYSTEM		2			
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	4	1	3		1

ENCODING/TRANSMITTING RESIDENT ASSESSMENT		1			
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	7	6	6	5	5
FACILITY MANAGEMENT OF PERSONAL FUNDS	6	11	9	5	9
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	1				
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	2	7	12		2
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	82	87	10	56	70
FREE FROM ABUSE/INVOLUNTARY SECLUSION	5	4	4	2	4
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	73	189	95	130	134
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	45	41	28	29	18
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	14	5	7	5	3
FREQUENCY OF MEALS/SNACKS AT BEDTIME	5	3	1	2	4
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	2	3	3	1	3
HOUSEKEEPING & MAINTENANCE SERVICES	55	42	9	34	19
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	20	23	12	23	17
INFECTION CONTROL, PREVENT SPREAD, LINENS	104	105	13	82	76
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	10	10	2	5	4
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	15	24	36	16	17
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	86	142	80	87	73
LAB REPORTS IN RECORD - LAB NAME/ADDRESS		1			
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN		1			
LIMITATION ON CHARGES TO PERSONAL FUNDS				1	1
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	9	3	62		8
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	3	2	1		
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	46	32	20	30	38
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	5	2	11	1	2
MAINTENANCE OF COMFORTABLE SOUND LEVELS	3	4	10	3	9
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	12	7	1	4	12
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	98	6	86	3	2
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE				1	1
NO CATHETER, PREVENT UTI, RESTORE BLADDER	38	32	14	24	29
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	1	2	1	2	2
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	1	10	14	3	3
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	45	28	10	30	21
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	8	3	11	1	3
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	14	67	58	51	42
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS		2	26	2	
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	14	11	4	12	3
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	6	9	2	4	4
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	2		3	1	2

NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	24	24	78	32	23
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	3	1			
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY			3		1
PASRR REQUIREMENTS FOR MI & MR	74	16	34	11	24
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	27	13	13	9	16
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	1		15		
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	19	25	7	21	21
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR			2		
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1	1	1	1	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	4	2	2		1
POSTED NURSE STAFFING INFORMATION	6	14	6	10	17
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	6	4	5	5	4
PROCEDURES TO ENSURE WATER AVAILABILITY	7	5	3	3	
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	94	8	7		5
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	1	5	12		1
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	73	151	90	134	141
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS			1	1	1
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	3	5	13	6	5
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT		1	1	3	
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	45	57	36	48	44
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	2	11	11	12	7
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	2		26		
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS					2
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS			2		
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	10	34	25	19	10
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	3	6	2	2	5
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	2	1			
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	3			1	
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	1	4	83	3	2
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	24	54	17	39	41
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	9	9	7	7	10
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	7	11	4	7	11
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	23	33	34	42	25
RESPONSIBILITIES OF MEDICAL DIRECTOR		1	4	1	
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS		1	2	2	
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	1			1	
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	8	8	5	1	2
RIGHT TO CHOOSE A PERSONAL PHYSICIAN				1	
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	6	4	2	1	4

RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES		1	8		
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	7	6	3	14	10
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	1	1	8		
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	109	59	5	46	44
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	4	4	6	1	3
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	8	24	22	15	16
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	4	3	22	4	7
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	11	6	2	9	6
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	3	5	1	1	4
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL			4	1	
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	5	1			1
RIGHTS EXERCISED BY REPRESENTATIVE	1			1	1
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	1	4	5	15	22
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	11	5	63	4	11
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	8	9	31	12	9
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	2	6	3	1	14
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	11	11	5	23	35
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	15	34	42	38	44
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	130	154	138	61	41
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	1		17		2
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	9	11	9	10	12
SUFFICIENT DIETARY SUPPORT PERSONNEL	4	1	4		3
SUFFICIENT FLUID TO MAINTAIN HYDRATION	8	6	36	13	10
SURETY BOND - SECURITY OF PERSONAL FUNDS		1		1	
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	6		3	1	1
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	13	15	8	10	8
TRANSFER AGREEMENT WITH HOSPITAL				1	
TREATMENT/CARE FOR SPECIAL NEEDS	45	32	33	19	14
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	1	4	5	4	3
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	26	12	87	9	14
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	58	54	49	37	43
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	2	5	3	5	1
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	7	3	22	1	3
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	5	5	3	1	1
Grand Total	**2432**	**2547**	**2466**	**1935**	**1970**

Intermediate Care Facilities for Individuals with Intellectual Disabilities	FY2012	FY 2013	FY2014
Chapter Description	Count of Total	Count of Total	Count of Total
ACTIVE TREATMENT			1
CLIENT BATHROOMS		1	
CLIENT RECORDS		1	1
COMMUNICATION WITH CLIENTS, PARENTS &	1		
COMPLIANCE W FEDERAL, STATE & LOCAL LAWS		2	3
CONDUCT TOWARD CLIENT	2	1	1
DINING AREAS AND SERVICE	1		1
DIRECT CARE STAFF		2	1
DRUG ADMINISTRATION	2	1	3
DRUG REGIMEN REVIEW		2	1
DRUG STORAGE AND RECORDKEEPING		2	
DRUG USAGE			2
EVACUATION DRILLS	4	3	4
FLOORS	1	1	
FOOD AND NUTRITION SERVICES		1	1
GOVERNING BODY	2	4	2
INDIVIDUAL PROGRAM PLAN	2	2	4
INFECTION CONTROL		4	3
MEAL SERVICES		3	
MENUS		1	1
MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	1	1	
NURSING SERVICES		7	
PHYSICIAN SERVICES		4	7
PROFESSIONAL PROGRAM SERVICES		1	
PROGRAM DOCUMENTATION		1	1
PROGRAM IMPLEMENTATION		1	3
PROGRAM MONITORING & CHANGE	3	13	6
PROTECTION OF CLIENTS RIGHTS	2	3	3
QUALIFIED MENTAL RETARDATION PROFESSIONAL		1	1
SERVICES PROVIDED WITH OUTSIDE SOURCES		1	
STAFF TRAINING PROGRAM	1	2	1
STAFF TREATMENT OF CLIENTS	10	6	8
Grand Total	**32**	**72**	**59**

Certified Community Residential Services and Supports	FY2012	FY 2013	FY2014
Chapter Description	Count of Total	Count of Total	Count of Total
4170: Mandated reporting policies and procedures	3	1	3
3630: Medication services—General.	12	5	6
3870: Client protection	2	1	1
3520: Shared expenses and client related funds	2	2	0
3530: Individual financial plan	2	0	0
3320: Client rights	40	26	17
3240: Policies and procedures	3	3	7
3220: Administrator responsibilities and training	3	1	1
3630: Medication services—General	12	5	6
3370: Client health services support	6	3	7
3360: Client services	4	4	9
3860: Positive behavior support plan	13	17	10
3020: Compliance	3	0	0
3470: Development of the individual instruction and support plan	2	1	0
3700: Storage of medications.	1	1	1
3540: Managing client funds	2	1	0
3820: Client's property records	2	0	0
4150: Mandated reporting to the department	19	19	0
4160: Mandated reporting to law enforcement	10	12	18
3610: Client reimbursement	2	0	1
3420: Client refusal to participate in services	1	0	0
3440: Changes in client service needs—Emergent	1	0	1
3510: Ongoing updating of the individual instruction and support plan.	1	0	0
3660: Medication assistance.	1	0	0
3900: Restrictive procedures approval.	1	0	0
3190: Service provider responsibilities.	2	2	0
3390: Physical and safety requirements.	4	2	4
3372: Medical devices.	4	0	0
3330: Treatment of clients.	6	2	4
3375: Nurse delegation.	2	0	0
3150: State and federal access to program	2	0	1
3850: Functional assessment.	3	2	4
3500: Accessibility of the individual instruction and support plan	1	0	1
4030: Community protection—Client transportation	1	0	0
3250: Background checks—Requirements for service providers	8	7	5
3200: Staffing requirements.	1	1	3

3580: Client financial records.	1	1	0
3970: Community protection—Approval	1	0	0
4000: Community protection—Staff training	1	1	0
3550: Reconciling and verifying client accounts.	2	1	0
3980: Community protection—Policies and procedures	1	1	2
4010: Community protection—Treatment plan	1	1	1
3640: Medication—Types of support	0	1	0
3720: Medications—Documentation	0	2	1
3670: Medication administration—Nurse delegation.	0	1	1
3255: Background checks—Provisional hire—Pending results.	0	2	1
3160: Plan of correction	0	1	1
3800: Retention of client records	0	0	1
3590: Transferring client funds.	0	0	1
Grand Total	**189**	**130**	**119**

Reports Used

Regulations Cited

AFH & ALF - RCS Report Fac1008_CitationFrequency
NH - S & C PDQ Report citation_frequency
ICFIID - Data collected by the unit; no data prior to FY2012
CCRSS - Data is collected by the unit; no data prior to FY2012

Nursing Home

FY2014
Top 5 citation categories with description

FY2014 Citation Category	Description
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309: This tag encompasses a number of areas in which the facility is expected to ensure the resident receives all necessary services to meet his/her highest level of function (and avoid a decline in that function unless the decline is reasonably expected related to the resident diagnosis). The categories in this tag include: dementia, dialysis, pain, hospice, non-pressure related skin ulcers, diabetes, fractures, and fecal impaction
FREE OF ACCIDENT HAZARDS/SUPER-VISION/DEVICES	F 323: The facility must keep residents free from accidents and hazards, including the potential for accidents. The facility should keep the physical environment and all equipment in good repair. If the facility has an awareness a resident is a potential for injury (i.e.: history of falls), the facility must implement plans to minimize or eliminate the resident risk for injuries.
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329: The facility will ensure the resident only takes the medications needed, in the lowest dose possible to address the problem, and will ensure the medication(s) do not have adverse consequences to the resident and the medications do not have the potential for an adverse reaction with other medications the resident is taking. The facility will ensure that all appropriate monitoring occurs with the medication (Blood pressure checks, blood sugar checks, labs) and the facility will attempt to reduce the dose periodically for those medications that are considered psychotropic medications. The facility will not inappropriately utilize psychotropic medications to control "unwanted" behaviors
DEVELOP COMPREHENSIVE CARE PLANS	F 279: The facility will create a care plan outlining the care and services required for the resident to reach his/her highest level of function and well-being. The care plan will be based on an assessment.
DIGNITY AND RESPECT OF INDIVIDUALITY	F 241: The facility must provide care in a manner that respects the resident's dignity and individuality. This can include recognizing privacy, allowing the resident to act as he/she would if in their own home (appropriate grooming without food all over clothes or in hair, appropriate dress for the time of day, attending activities he/she likes, using dishware rather than paper plates and cups, etc.), maintaining a sense of self-esteem.

List of all citation categories for FY 2014

Nursing Home	FY2014
Chapter Description	Total Citations
ACCESS TO STATIONERY/POSTAGE/PENS, ETC	
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	24
ADEQUATE & COMFORTABLE LIGHTING LEVELS	1
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	38
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	1
ADMINISTRATION	
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	3
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	18
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	2
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	
BEDROOMS ASSURE FULL VISUAL PRIVACY	2
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR	
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	11
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	5
CLEAN BED/BATH LINENS IN GOOD CONDITION	1
COMFORTABLE & SAFE TEMPERATURE LEVELS	3
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	1
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	3
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	
COMPREHENSIVE ASSESSMENTS	35
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	3
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	1
DEVELOP COMPREHENSIVE CARE PLANS	81
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	33
DIGNITY AND RESPECT OF INDIVIDUALITY	78
DISPOSE GARBAGE & REFUSE PROPERLY	2
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	1
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	61
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	97
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	9
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	8
EMERGENCY ELECTRICAL POWER SYSTEM	
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	1
ENCODING/TRANSMITTING RESIDENT ASSESSMENT	
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	5
FACILITY MANAGEMENT OF PERSONAL FUNDS	9
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	2
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	70
FREE FROM ABUSE/INVOLUNTARY SECLUSION	4
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	134
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	18
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	3
FREQUENCY OF MEALS/SNACKS AT BEDTIME	4
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	3
HOUSEKEEPING & MAINTENANCE SERVICES	19

Chapter Description	Total Citations
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	17
INFECTION CONTROL, PREVENT SPREAD, LINENS	76
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	4
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	17
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	73
LAB REPORTS IN RECORD - LAB NAME/ADDRESS	
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	
LIMITATION ON CHARGES TO PERSONAL FUNDS	1
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	8
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	38
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	2
MAINTENANCE OF COMFORTABLE SOUND LEVELS	9
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	12
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	2
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE	1
NO CATHETER, PREVENT UTI, RESTORE BLADDER	29
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	2
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	3
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	21
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	3
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	42
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	3
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	4
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	2
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	23
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY	1
PASRR REQUIREMENTS FOR MI & MR	24
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	16
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	21
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR	
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	1
POSTED NURSE STAFFING INFORMATION	17
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	4
PROCEDURES TO ENSURE WATER AVAILABILITY	
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	5
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	1
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	141
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	1
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	5
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	44
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	7
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	2
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	10
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	5

Chapter Description	Total Citations
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	2
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	41
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	10
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	11
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	25
RESPONSIBILITIES OF MEDICAL DIRECTOR	
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS	
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	2
RIGHT TO CHOOSE A PERSONAL PHYSICIAN	
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	4
RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES	
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	10
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	44
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	3
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	16
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	7
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	6
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	4
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	1
RIGHTS EXERCISED BY REPRESENTATIVE	1
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	22
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	11
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	9
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	14
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	35
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	44
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	41
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	2
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	12
SUFFICIENT DIETARY SUPPORT PERSONNEL	3
SUFFICIENT FLUID TO MAINTAIN HYDRATION	10
SURETY BOND - SECURITY OF PERSONAL FUNDS	
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	1
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	8
TRANSFER AGREEMENT WITH HOSPITAL	
TREATMENT/CARE FOR SPECIAL NEEDS	14
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	3
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	14
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	43
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	1
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	3
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	1
Grand Total	**1970**

Nursing Home

FY2013
Top 5 citation categories with description

FY2013 Citation Category	Description
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309: This tag encompasses a number of areas in which the facility is expected to ensure the resident receives all necessary services to meet his/her highest level of function (and avoid a decline in that function unless the decline is reasonably expected related to the resident diagnosis). The categories in this tag include: dementia, dialysis, pain, hospice, non-pressure related skin ulcers, diabetes, fractures, and fecal impaction
FREE OF ACCIDENT HAZARDS/SUPER-VISION/DEVICES	F 323: The facility must keep residents free from accidents and hazards, including the potential for accidents. The facility should keep the physical environment and all equipment in good repair. If the facility has an awareness a resident is a potential for injury (i.e.: history of falls), the facility must implement plans to minimize or eliminate the resident risk for injuries.
INVESTIGATE/ REPORT ALLEGATIONS/ INDIVIDUALS	F 225: The facility must not employ an individual who has been found guilty of abusing, neglecting, and/or mistreating resident. The facility must ensure that all allegations of abuse, neglect, mistreatment, and/or misappropriation of property are thoroughly investigated and reported to the proper officials (DSHS hotline, Law enforcement, coroner, etc.)
DIGNITY AND RESPECT OF INDIVIDUALITY	F 241: The facility must provide care in a manner that respects the resident's dignity and individuality. This can include recognizing privacy, allowing the resident to act as he/she would if in their own home (appropriate grooming without food all over clothes or in hair, appropriate dress for the time of day, attending activities he/she likes, using dishware rather than paper plates and cups, etc.), maintaining a sense of self-esteem.
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329: The facility will ensure the resident only takes the medications needed, in the lowest dose possible to address the problem, and will ensure the medication(s) do not have adverse consequences to the resident and the medications do not have the potential for an adverse reaction with other medications the resident is taking. The facility will ensure that all appropriate monitoring occurs with the medication (Blood pressure checks, blood sugar checks, labs) and the facility will attempt to reduce the dose periodically for those medications that are considered psychotropic medications. The facility will not inappropriately utilize psychotropic medications to control "unwanted" behaviors

List of all citation categories for FY 2013

Nursing Home	FY 2013
Chapter Description	Total Citations
ACCESS TO STATIONERY/POSTAGE/PENS, ETC	
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	16
ADEQUATE & COMFORTABLE LIGHTING LEVELS	
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	27
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	
ADMINISTRATION	1
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	2
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	2
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	1
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	6
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	
BEDROOMS ASSURE FULL VISUAL PRIVACY	
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR	
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	11
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	
CLEAN BED/BATH LINENS IN GOOD CONDITION	
COMFORTABLE & SAFE TEMPERATURE LEVELS	4
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	
COMPREHENSIVE ASSESSMENTS	47
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	1
DEVELOP COMPREHENSIVE CARE PLANS	82
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	40
DIGNITY AND RESPECT OF INDIVIDUALITY	87
DISPOSE GARBAGE & REFUSE PROPERLY	1
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	59
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	86
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	17
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	9
EMERGENCY ELECTRICAL POWER SYSTEM	
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	
ENCODING/TRANSMITTING RESIDENT ASSESSMENT	
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	5
FACILITY MANAGEMENT OF PERSONAL FUNDS	5
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	56
FREE FROM ABUSE/INVOLUNTARY SECLUSION	2
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	130
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	29
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	5
FREQUENCY OF MEALS/SNACKS AT BEDTIME	2
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	1
HOUSEKEEPING & MAINTENANCE SERVICES	34

Chapter Description	Total Citations
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	23
INFECTION CONTROL, PREVENT SPREAD, LINENS	82
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	5
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	16
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	87
LAB REPORTS IN RECORD - LAB NAME/ADDRESS	
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	
LIMITATION ON CHARGES TO PERSONAL FUNDS	1
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	30
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	1
MAINTENANCE OF COMFORTABLE SOUND LEVELS	3
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	4
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	3
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE	1
NO CATHETER, PREVENT UTI, RESTORE BLADDER	24
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	2
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	3
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	30
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	1
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	51
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	2
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	12
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	4
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	1
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	32
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY	
PASRR REQUIREMENTS FOR MI & MR	11
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	9
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	21
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR	
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	
POSTED NURSE STAFFING INFORMATION	10
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	5
PROCEDURES TO ENSURE WATER AVAILABILITY	3
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	134
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	1
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	6
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	3
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	48
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	12
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	19
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	2

Chapter Description	Total Citations
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	1
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	3
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	39
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	7
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	7
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	42
RESPONSIBILITIES OF MEDICAL DIRECTOR	1
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS	2
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	1
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	1
RIGHT TO CHOOSE A PERSONAL PHYSICIAN	1
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	1
RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES	
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	14
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	46
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	1
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	15
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	4
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	9
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	1
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	1
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	
RIGHTS EXERCISED BY REPRESENTATIVE	1
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	15
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	4
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	12
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	1
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	23
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	38
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	61
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	10
SUFFICIENT DIETARY SUPPORT PERSONNEL	
SUFFICIENT FLUID TO MAINTAIN HYDRATION	13
SURETY BOND - SECURITY OF PERSONAL FUNDS	1
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	1
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	10
TRANSFER AGREEMENT WITH HOSPITAL	1
TREATMENT/CARE FOR SPECIAL NEEDS	19
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	4
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	9
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	37
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	5
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	1
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	1
Grand Total	**1935**

Nursing Home

FY2012
Top 5 citation categories with description

FY2012 Citation Category	Description
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281: Assuring each discipline in the facility is acting in accordance with his/her professional standards. For example, nursing standards include the 5 Rights to be followed during medication administration (right resident, right drug, right dose, right route, right time). If a medication error occurs, professional standards were not followed. This tag may be cited any time a standard of practice for a discipline was not followed.
FREE OF ACCIDENT HAZARDS/SUPER-VISION/DEVICES	F 323: The facility must keep residents free from accidents and hazards, including the potential for accidents. The facility should keep the physical environment and all equipment in good repair. If the facility has an awareness a resident is a potential for injury (i.e.: history of falls), the facility must implement plans to minimize or eliminate the resident risk for injuries.
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309: This tag encompasses a number of areas in which the facility is expected to ensure the resident receives all necessary services to meet his/her highest level of function (and avoid a decline in that function unless the decline is reasonably expected related to the resident diagnosis). The categories in this tag include: dementia, dialysis, pain, hospice, non-pressure related skin ulcers, diabetes, fractures, and fecal impaction
TREATMENT/ SERVICES TO IMPROVE/ MAINTAIN ADLS	F 311: The facility must continually work with residents to improve their level of function in ADLs. ADL's can include bathing, dressing, grooming, transferring, and toileting. If the facility is unable to assist the resident with improvement (due to resident physical and cognitive status), the facility must ensure the resident does not decline in ADL abilities (unless reasonably related to his/her condition)
NG TREATMENT/ SERVICES - RESTORE EATING SKILLS	F 322: The facility must ensure that a resident who can eat with or without assistance is not fed with a Naso-gastric (NG) tube. If a resident does require a NG tube, the facility ensures the resident receives appropriate care and services to prevent aspiration, stomach problems, and/or dehydration, and the facility assists the resident in trying to restore normal eating

List of all citation categories for FY 2012

Nursing Home	FY2012
Chapter Description	Total Citations
ACCESS TO STATIONERY/POSTAGE/PENS, ETC	
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	4
ADEQUATE & COMFORTABLE LIGHTING LEVELS	3
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	55
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	14
ADMINISTRATION	18
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	14
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	11
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	41
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	
BEDROOMS ASSURE FULL VISUAL PRIVACY	68
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR	
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	2
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	1
CLEAN BED/BATH LINENS IN GOOD CONDITION	48
COMFORTABLE & SAFE TEMPERATURE LEVELS	23
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	24
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	9
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	
COMPREHENSIVE ASSESSMENTS	40
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	3
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	4
DEVELOP COMPREHENSIVE CARE PLANS	85
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	31
DIGNITY AND RESPECT OF INDIVIDUALITY	65
DISPOSE GARBAGE & REFUSE PROPERLY	
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	9
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	23
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	2
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	5
EMERGENCY ELECTRICAL POWER SYSTEM	
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	3
ENCODING/TRANSMITTING RESIDENT ASSESSMENT	
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	6
FACILITY MANAGEMENT OF PERSONAL FUNDS	9
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	12
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	10
FREE FROM ABUSE/INVOLUNTARY SECLUSION	4
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	95
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	28
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	7
FREQUENCY OF MEALS/SNACKS AT BEDTIME	1
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	3
HOUSEKEEPING & MAINTENANCE SERVICES	9

Chapter Description	Total Citations
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	12
INFECTION CONTROL, PREVENT SPREAD, LINENS	13
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	2
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	36
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	80
LAB REPORTS IN RECORD - LAB NAME/ADDRESS	
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	
LIMITATION ON CHARGES TO PERSONAL FUNDS	
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	62
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	1
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	20
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	11
MAINTENANCE OF COMFORTABLE SOUND LEVELS	10
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	1
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	86
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE	
NO CATHETER, PREVENT UTI, RESTORE BLADDER	14
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	1
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	14
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	10
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	11
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	58
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	26
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	4
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	2
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	3
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	78
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY	3
PASRR REQUIREMENTS FOR MI & MR	34
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	13
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	15
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	7
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR	2
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	2
POSTED NURSE STAFFING INFORMATION	6
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	5
PROCEDURES TO ENSURE WATER AVAILABILITY	3
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	7
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	12
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	90
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	1
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	13
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	1
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	36
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	11
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	26
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	2
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	25
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	2

Chapter Description	Total Citations
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	83
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	17
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	7
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	4
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	34
RESPONSIBILITIES OF MEDICAL DIRECTOR	4
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS	2
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	5
RIGHT TO CHOOSE A PERSONAL PHYSICIAN	
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	2
RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES	8
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	3
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	8
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	5
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	6
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	22
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	22
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	2
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	1
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	4
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	
RIGHTS EXERCISED BY REPRESENTATIVE	
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	5
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	63
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	31
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	3
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	5
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	42
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	138
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	17
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	9
SUFFICIENT DIETARY SUPPORT PERSONNEL	4
SUFFICIENT FLUID TO MAINTAIN HYDRATION	36
SURETY BOND - SECURITY OF PERSONAL FUNDS	
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	3
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	8
TRANSFER AGREEMENT WITH HOSPITAL	
TREATMENT/CARE FOR SPECIAL NEEDS	33
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	5
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	87
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	49
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	3
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	22
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	3
Grand Total	**2466**

Nursing Home

FY2011
Top 5 citation categories with description

FY2011 Citation Category	Description
FREE OF ACCIDENT HAZARDS/SUPER-VISION/DEVICES	F 323: The facility must keep residents free from accidents and hazards, including the potential for accidents. The facility should keep the physical environment and all equipment in good repair. If the facility has an awareness a resident is a potential for injury (ie: history of falls), the facility must implement plans to minimize or eliminate the resident risk for injuries.
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281: Assuring each discipline in the facility is acting in accordance with his/her professional standards. For example, nursing standards include the 5 Rights to be followed during medication administration (right resident, right drug, right dose, right route, and right time). If a medication error occurs, professional standards were not followed. This tag may be cited any time a standard of practice for a discipline was not followed.
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309: This tag encompasses a number of areas in which the facility is expected to ensure the resident receives all necessary services to meet his/her highest level of function (and avoid a decline in that function unless the decline is reasonably expected related to the resident diagnosis). The categories in this tag include: dementia, dialysis, pain, hospice, non-pressure related skin ulcers, diabetes, fractures, and fecal impaction
INVESTIGATE/ REPORT ALLEGATIONS/ INDIVIDUALS	F 225: The facility must not employ an individual who has been found guilty of abusing, neglecting, and/or mistreating resident. The facility must ensure that all allegations of abuse, neglect, mistreatment, and/or misappropriation of property are thoroughly investigated and reported to the proper officials (DSHS hotline, Law enforcement, coroner, etc.)
INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441: The facility must create and implement policies to prevent the spread of infections. The facility must also record and analyze in house infection data for quality assurance purposes. The facility must create a system for laundering and distribution of linens in a manor to prevent the spread of infections.

List of all citation categories for FY 2011

Nursing Home	FY2011
Chapter Description	Total Citations
ACCESS TO STATIONERY/POSTAGE/PENS, ETC	1
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	25
ADEQUATE & COMFORTABLE LIGHTING LEVELS	1
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	1
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	44
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	2
ADMINISTRATION	5
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	1
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	6
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	1
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	1
BEDROOMS ASSURE FULL VISUAL PRIVACY	1
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR	1
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	9
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	
CLEAN BED/BATH LINENS IN GOOD CONDITION	1
COMFORTABLE & SAFE TEMPERATURE LEVELS	2
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	4
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	3
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	
COMPREHENSIVE ASSESSMENTS	82
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	4
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	1
DEVELOP COMPREHENSIVE CARE PLANS	97
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	66
DIGNITY AND RESPECT OF INDIVIDUALITY	79
DISPOSE GARBAGE & REFUSE PROPERLY	3
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	49
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	101
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	24
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	13
EMERGENCY ELECTRICAL POWER SYSTEM	2
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	1
ENCODING/TRANSMITTING RESIDENT ASSESSMENT	1
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	6
FACILITY MANAGEMENT OF PERSONAL FUNDS	11
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	7
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	87
FREE FROM ABUSE/INVOLUNTARY SECLUSION	4
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	189
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	41
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	5
FREQUENCY OF MEALS/SNACKS AT BEDTIME	3
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	3
HOUSEKEEPING & MAINTENANCE SERVICES	42

Chapter Description	Total Citations
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	23
INFECTION CONTROL, PREVENT SPREAD, LINENS	105
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	10
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	24
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	142
LAB REPORTS IN RECORD - LAB NAME/ADDRESS	1
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	1
LIMITATION ON CHARGES TO PERSONAL FUNDS	
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	3
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	2
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	32
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	2
MAINTENANCE OF COMFORTABLE SOUND LEVELS	4
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	7
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	6
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE	
NO CATHETER, PREVENT UTI, RESTORE BLADDER	32
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	2
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	10
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	28
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	3
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	67
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	2
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	11
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	9
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	24
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	1
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY	
PASRR REQUIREMENTS FOR MI & MR	16
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	13
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	25
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR	
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	2
POSTED NURSE STAFFING INFORMATION	14
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	4
PROCEDURES TO ENSURE WATER AVAILABILITY	5
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	8
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	5
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	151
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	5
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	1
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	57
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	11
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	34
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	6

Chapter Description	Total Citations
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	1
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	4
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	54
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	9
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	11
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	33
RESPONSIBILITIES OF MEDICAL DIRECTOR	1
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS	1
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	8
RIGHT TO CHOOSE A PERSONAL PHYSICIAN	
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	4
RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES	1
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	6
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	1
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	59
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	4
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	24
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	3
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	6
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	5
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	1
RIGHTS EXERCISED BY REPRESENTATIVE	
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	4
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	5
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	9
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	6
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	11
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	34
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	154
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	11
SUFFICIENT DIETARY SUPPORT PERSONNEL	1
SUFFICIENT FLUID TO MAINTAIN HYDRATION	6
SURETY BOND - SECURITY OF PERSONAL FUNDS	1
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	15
TRANSFER AGREEMENT WITH HOSPITAL	
TREATMENT/CARE FOR SPECIAL NEEDS	32
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	4
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	12
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	54
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	5
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	3
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	5
Grand Total	**2547**

Nursing Home

FY2010
Top 5 citation categories with description

FY2010 Citation Category	Description
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281: Assuring each discipline in the facility is acting in accordance with his/her professional standards. For example, nursing standards include the 5 Rights to be followed during medication administration (right resident, right drug, right dose, right route, right time). If a medication error occurs, professional standards were not followed. This tag may be cited any time a standard of practice for a discipline was not followed.
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280: When a resident has a decline or improvement in function, the care plan should be adjusted to reflect the new level of care and services that need to be provided. This citation usually occurs if the care plan is not regularly updates, and does not reflect the resident's current level of care needs. This Citation can also be used if the resident/resident representative was not included in the care planning process
INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441: The facility must create and implement policies to prevent the spread of infections. The facility must also record and analyze in house infection data for quality assurance purposes. The facility must create a system for laundering and distribution of linens in a manor to prevent the spread of infections.
NG TREATMENT/ SERVICES - RESTORE EATING SKILLS	F 322: The facility must ensure that a resident who can eat with or without assistance is not fed with a Naso-gastric (NG) tube. If a resident does require a NG tube, the facility ensures the resident receives appropriate care and services to prevent aspiration, stomach problems, and/or dehydration, and the facility assists the resident in trying to restore normal eating
PROHIBIT MISTREATMENT/NEGLECT /MISAPPROPRIATION	F 224 and F 226: The facility must ensure the resident is free from mistreatment, neglect, and misappropriation of property. The facility must develop written policies and procedures that prohibit mistreatment, neglect, abuse, and misappropriation of property.

List of all citation categories for FY 2010

Nursing Home	FY2010
Chapter Description	Total Citations
ACCESS TO STATIONERY/POSTAGE/PENS, ETC	
ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	55
ADEQUATE & COMFORTABLE LIGHTING LEVELS	1
ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	2
ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	58
ADLS DO NOT DECLINE UNLESS UNAVOIDABLE	1
ADMINISTRATION	3
ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	
ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN	1
ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS	2
ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	28
ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS	1
BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET	1
BEDROOMS ASSURE FULL VISUAL PRIVACY	1
BEDROOMS HAVE DIRECT ACCESS TO EXIT CORRIDOR	
BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	12
CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE	1
CLEAN BED/BATH LINENS IN GOOD CONDITION	
COMFORTABLE & SAFE TEMPERATURE LEVELS	4
COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD	3
COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	9
COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS	1
COMPREHENSIVE ASSESSMENTS	58
CONVEYANCE OF PERSONAL FUNDS UPON DEATH	3
CORRIDORS HAVE FIRMLY SECURED HANDRAILS	1
DEVELOP COMPREHENSIVE CARE PLANS	75
DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	60
DIGNITY AND RESPECT OF INDIVIDUALITY	64
DISPOSE GARBAGE & REFUSE PROPERLY	4
DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES	9
DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	27
DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	82
DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	8
EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	11
EMERGENCY ELECTRICAL POWER SYSTEM	
EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	4
ENCODING/TRANSMITTING RESIDENT ASSESSMENT	
ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	7
FACILITY MANAGEMENT OF PERSONAL FUNDS	6
FEEDING ASST - TRAINING/SUPERVISION/RESIDENT	1
FOOD IN FORM TO MEET INDIVIDUAL NEEDS	2
FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	82
FREE FROM ABUSE/INVOLUNTARY SECLUSION	5
FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	73
FREE OF MEDICATION ERROR RATES OF 5% OR MORE	45
FREQUENCY & TIMELINESS OF PHYSICIAN VISIT	14
FREQUENCY OF MEALS/SNACKS AT BEDTIME	5
GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	2
HOUSEKEEPING & MAINTENANCE SERVICES	55

Chapter Description	Total Citations
INCREASE/PREVENT DECREASE IN RANGE OF MOTION	20
INFECTION CONTROL, PREVENT SPREAD, LINENS	104
INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	10
INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	15
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	86
LAB REPORTS IN RECORD - LAB NAME/ADDRESS	
LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN	
LIMITATION ON CHARGES TO PERSONAL FUNDS	
LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	9
MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS	3
MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	46
MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	5
MAINTENANCE OF COMFORTABLE SOUND LEVELS	3
MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED	12
NG TREATMENT/SERVICES - RESTORE EATING SKILLS	98
NO BEHAVIOR DIFFICULTIES UNLESS UNAVOIDABLE	
NO CATHETER, PREVENT UTI, RESTORE BLADDER	38
NO REDUCTION IN ROM UNLESS UNAVOIDABLE	1
NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR	1
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	45
NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	8
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	14
NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS	
NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	14
NURSE AIDE REGISTRY VERIFICATION, RETRAINING	6
NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY	2
NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	24
OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT	3
PARTICIPATE IN SOCIAL/RELIGIOUS ACT/COMMUNITY	
PASRR REQUIREMENTS FOR MI & MR	74
PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	27
PERSONAL VISITS BY PHYSICIAN, ALTERNATE PA/NP	1
PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	19
PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR	
PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	1
POLICY TO PERMIT READMISSION BEYOND BED-HOLD	4
POSTED NURSE STAFFING INFORMATION	6
PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	6
PROCEDURES TO ENSURE WATER AVAILABILITY	7
PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	94
PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS	1
PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	73
PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	
PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES	3
PROVIDED DIET MEETS NEEDS OF EACH RESIDENT	
PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	45
QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	2
QUALIFICATIONS OF ACTIVITY PROFESSIONAL	2
QUALIFICATIONS OF SOCIAL WORKER > 120 BEDS	
QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS	
REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	10
REASONS FOR TRANSFER/DISCHARGE OF RESIDENT	3

Chapter Description	Total Citations
REHAB SVCS - PHYSICIAN ORDER/QUALIFIED PERSON	2
RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS	3
REQUIREMENTS FOR DINING & ACTIVITY ROOMS	1
RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	24
RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	9
RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	7
RESIDENTS FREE OF SIGNIFICANT MED ERRORS	23
RESPONSIBILITIES OF MEDICAL DIRECTOR	
RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS	
RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS	1
RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	8
RIGHT TO CHOOSE A PERSONAL PHYSICIAN	
RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL	6
RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES	
RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	7
RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP	1
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	109
RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL	4
RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	8
RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	4
RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	11
RIGHT TO TELEPHONE ACCESS WITH PRIVACY	3
RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	
RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS	5
RIGHTS EXERCISED BY REPRESENTATIVE	1
ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	1
ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS	11
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	8
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	2
SELF-DETERMINATION - RIGHT TO MAKE CHOICES	11
SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	15
SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	130
SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	1
SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	9
SUFFICIENT DIETARY SUPPORT PERSONNEL	4
SUFFICIENT FLUID TO MAINTAIN HYDRATION	8
SURETY BOND - SECURITY OF PERSONAL FUNDS	
THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	6
TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS	13
TRANSFER AGREEMENT WITH HOSPITAL	
TREATMENT/CARE FOR SPECIAL NEEDS	45
TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	1
TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	26
TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	58
TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES	2
WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON	7
WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS	5
Grand Total	**2432**

Adult Family Home

FY2014
Top 5 citation categories with description

FY2014 Citation Category	Description
Administration-General	WAC's 388-76-10191 through 10230. This category covers general administration of the home including Liability insurance coverage, ensuring enough staff are in the home and readily available to meet client needs, personnel records, following the terms and conditions of a Medicaid contract, protection of resident funds, and reporting requirements for abuse, neglect, abandonment or exploitation of a resident.
Negotiated Care Plan	WAC's 388-76-10355 through 10385. Includes the requirement to develop a plan of care for a resident within 30 days of admission and the timeframes for updates to the plan of care. Also covers requirements for who is involved in the plan and who signs the plan of care.
Physical Plant Basic Requirements	WAC's 388-76-10685 through 10795. Includes bedroom size and bedroom capacity, the need to follow all federal, state and local building codes, requirement for common use areas, the need for grab bars in the bathroom, adequate water temperatures, adequate facility temperature, adequate water supply, window size, and safety and maintenance requirements.
Resident Medications	WAC's 388-76-10430 through 10490 Includes expectations of a system for medication delivery and monitoring, Documentation of medications resident refusal of medication, medication administration levels (from independence to total assist with medications), altering of medication (crushing or cutting pills), appropriate use of medication organizers, and policies for appropriate disposal of unused medication
Resident Rights	WAC's 388-76-10510 through 10615 Includes resident right to exercise civil and legal rights, and receive notice of his/her rights. The right to notice of all services and charges for the services, the right to know about the staff in the home, the right to privacy, voice grievances, have visitors, and have access to advocates, the right to personal space and storage, the right to telephone and mail privacy. The right to a safe and orderly discharge (if the discharge is appropriate). The right not to sign a waiver of liability.

List of all citation categories for FY 2014

Adult Family Home	FY2014
Chapter Description	**Count of Total**
Abuse	269
Abuse, punishment, seclusion	1
Administration-General	941
Adult family home provider, resident manager	1
Adult family homes	1
Advocacy, access, and visitation rights	
Basic Training	79
Care and Services	591
Competency Training	
Continuing Education	412
CPR and First Aid Training	196
Criminal History Background Check	563
Curriculum Approval	26
Department authority to take actions in response to noncompliance	
Disaster and Emergency Preparedness	171
Disclosure of fees and notice requirements	1
Disclosure, transfer, and discharge requirements	14
Facility's policy on accepting Medicaid as a payment source	
Fire Drill Plan for Emergency Evacuation	355
Fire Protection	283
Food Services	134
Granting or Denying a License	25
Health Care Decision Making	202
Infection Control and Communicable Disease	85
Informal Dispute Resolution, Notice and Appeals	
Inspections--Complaint Investigations--Monitoring Visits	26
Instructor Approval	24
License	199
License	
License Application	72
Long-term Caregiver training	
Management Agreements	
Medical Devices and Restraints	370
Modified Basic Training	
Negotiated Care Plan	1438
Notice of rights and services	8
Nurse Delegation Core Training	8
Orientation	173
Personal property	
Physical Plant Basic Requirements	1312
Privacy and confidentiality of personal and medical records	
Protection of resident's funds	5

Purpose and Definitions	1
Qualifications of Individuals Providing Care and Services	512
Quality of Life	67
Quality of Life	
Remedies	51
Required training and continuing education	
Resident Advocate Access	
Resident Assessment	359
Resident Medications	2500
Resident Protection Program	
Resident Records	317
Resident Rights	1662
Residential Care Administrator Training	
Rights are minimal	1
Specialty Care	13
Specialty Training	331
Toll-free telephone number for complaints	
Tuberculosis Screening	346
(blank)	
Grand Total	**14145**

Adult Family Home

FY2013
Top 5 citation categories with description

FY2013 Citation Category	Description
Administration-General	WAC's 388-76-10191 through 10230. This category covers general administration of the home including Liability insurance coverage, ensuring enough staff are in the home and readily available to meet client needs, personnel records, following the terms and conditions of a Medicaid contract, protection of resident funds, and reporting requirements for abuse, neglect, abandonment or exploitation of a resident
Negotiated Care Plan	WAC's 388-76-10355 through 10385. Includes the requirement to develop a plan of care for a resident within 30 days of admission and the timeframes for updates to the plan of care. Also covers requirements for who is involved in the plan and who signs the plan of care
Resident Medications	WAC's 388-76-10430 through 10490 Includes expectations of a system for medication delivery and monitoring, Documentation of medications resident refusal of medication, medication administration levels (from independence to total assist with medications), altering of medication (crushing or cutting pills), appropriate use of medication organizers, and policies for appropriate disposal of unused medication
Resident Rights	WAC's 388-76-10510 through 10615 Includes resident right to exercise civil and legal rights, and receive notice of his/her rights. The right to notice of all services and charges for the services, the right to know about the staff in the home, the right to privacy, voice grievances, have visitors, and have access to advocates, the right to personal space and storage, the right to telephone and mail privacy. The right to a safe and orderly discharge (if the discharge is appropriate). The right not to sign a waiver of liability.
Physical Plant Basic Requirements	WAC's 388-76-10685 through 10795. Includes bedroom size and bedroom capacity, the need to follow all federal, state and local building codes, requirement for common use areas, the need for grab bars in the bathroom, adequate water temperatures, adequate facility temperature, adequate water supply, window size, and safety and maintenance requirements

List of all citation categories for FY 2013

Adult Family Home	FY 2013
Chapter Description	**Total Citations**
Abuse	307
Abuse, punishment, seclusion	
Administration-General	976
Adult family home provider, resident manager	
Adult family homes	
Advocacy, access, and visitation rights	
Basic Training	14
Care and Services	637
Competency Training	2
Continuing Education	352
CPR and First Aid Training	155
Criminal History Background Check	590
Curriculum Approval	1
Department authority to take actions in response to noncompliance	3
Disaster and Emergency Preparedness	396
Disclosure of fees and notice requirements	3
Disclosure, transfer, and discharge requirements	
Facility's policy on accepting medicaid as a payment source	1
Fire Drill Plan for Emergency Evacuation	448
Fire Protection	314
Food Services	118
Granting or Denying a License	24
Health Care Decision Making	161
Infection Control and Communicable Disease	76
Inspections--Complaint Investigations--Monitoring Visits	27
Instructor Approval	2
License	226
License	
License Application	4
Long-term Caregiver training	7
Management Agreements	2
Medical Devices and Restraints	451
Modified Basic Training	2
Negotiated Care Plan	1698
Notice of rights and services	14
Nurse Delegation Core Training	15
Orientation	210
Personal property	1
Physical Plant Basic Requirements	1417
Privacy and confidentiality of personal and medical records	1
Protection of resident's funds	1
Qualifications of Individuals Providing Care and Services	626
Quality of Life	117
Quality of Life	4
Remedies	71

Chapter Description	Total Citations
Required training and continuing education	
Resident Advocate Access	
Resident Assessment	466
Resident Medications	2753
Resident Protection Program	1
Resident Records	429
Resident Rights	2502
Residential Care Administrator Training	3
Rights are minimal	
Specialty Care	32
Specialty Training	223
Toll-free telephone number for complaints	2
Tuberculosis Screening	371
Grand Total	**16256**

Adult Family Home

FY2012
Top 5 citation categories with description

FY2012 Citation Category	Description
Administration-General	WAC's 388-76-10191 through 10230. This category covers general administration of the home including Liability insurance coverage, ensuring enough staff are in the home and readily available to meet client needs, personnel records, following the terms and conditions of a Medicaid contract, protection of resident funds, and reporting requirements for abuse, neglect, abandonment or exploitation of a resident.
Negotiated Care Plan	WAC's 388-76-10355 through 10385. Includes the requirement to develop a plan of care for a resident within 30 days of admission and the timeframes for updates to the plan of care. Also covers requirements for who is involved in the plan and who signs the plan of care.
Physical Plant Basic Requirements	WAC's 388-76-10685 through 10795. Includes bedroom size and bedroom capacity, the need to follow all federal, state and local building codes, requirement for common use areas, the need for grab bars in the bathroom, adequate water temperatures, adequate facility temperature, adequate water supply, window size, and safety and maintenance requirements.
Resident Medications	WAC's 388-76-10430 through 10490 Includes expectations of a system for medication delivery and monitoring, Documentation of medications resident refusal of medication, medication administration levels (from independence to total assist with medications), altering of medication (crushing or cutting pills), appropriate use of medication organizers, and policies for appropriate disposal of unused medication
Resident Rights	WAC's 388-76-10510 through 10615 Includes resident right to exercise civil and legal rights, and receive notice of his/her rights. The right to notice of all services and charges for the services, the right to know about the staff in the home, the right to privacy, voice grievances, have visitors, and have access to advocates, the right to personal space and storage, the right to telephone and mail privacy. The right to a safe and orderly discharge (if the discharge is appropriate). The right not to sign a waiver of liability.

List of all citation categories for FY 2012

Adult Family Home	FY2012
Chapter Description	**Total Citations**
Abuse	580
Abuse, punishment, seclusion	1
Administration-General	1380
Basic Training	28
CARE AND SERVICES	711
Continuing Education	458
CPR and First Aid Training	253
Criminal History Background Check	597
Department authority to take actions in response to noncompliance	3
Disaster and Emergency Preparedness	537
Disclosure, transfer, and discharge requirements	4
Facility's policy on accepting Medicaid as a payment source	1
Fire Drill Plan for Emergency Evacuation	629
Fire Protection	364
Food Services	147
Granting or Denying a License	38
Health Care Decision Making	118
Infection Control and Communicable Disease	88
Informal Dispute Resolution, Notice and Appeals	1
Inspections--Complaint Investigations--Monitoring Visits	28
License	204
License Application	55
Medical Devices and Restraints	457
Modified Basic Training	6
Negotiated Care Plan	1518
Notice of rights and services	39
Nurse Delegation Core Training	10
Orientation	421
Physical Plant Basic Requirements	1640
Protection of resident's funds	5
Qualifications of Individuals Providing Care and Services	469
Quality of Life	110
Quality of life	1
Remedies	54
Resident Assessment	543
Resident Medications	3415
Resident Records	347
Resident Rights	2951
Residential Care Administrator Training	1
Specialty Care	19
Specialty Training	301
Tuberculosis Screening	554
(blank)	
Grand Total	**19086**

Adult Family Home

FY2011
Top 5 citation categories with description

FY2011 Citation Category	Description
Administration-General	WAC's 388-76-10191 through 10230. This category covers general administration of the home including Liability insurance coverage, ensuring enough staff are in the home and readily available to meet client needs, personnel records, following the terms and conditions of a Medicaid contract, protection of resident funds, and reporting requirements for abuse, neglect, abandonment or exploitation of a resident
Negotiated Care Plan	WAC's 388-76-10355 through 10385. Includes the requirement to develop a plan of care for a resident within 30 days of admission and the timeframes for updates to the plan of care. Also covers requirements for who is involved in the plan and who signs the plan of care
Resident Medications	WAC's 388-76-10430 through 10490 Includes expectations of a system for medication delivery and monitoring, Documentation of medications resident refusal of medication, medication administration levels (from independence to total assist with medications), altering of medication (crushing or cutting pills), appropriate use of medication organizers, and policies for appropriate disposal of unused medication
Resident Rights	WAC's 388-76-10510 through 10615 Includes resident right to exercise civil and legal rights, and receive notice of his/her rights. The right to notice of all services and charges for the services, the right to know about the staff in the home, the right to privacy, voice grievances, have visitors, and have access to advocates, the right to personal space and storage, the right to telephone and mail privacy. The right to a safe and orderly discharge (if the discharge is appropriate). The right not to sign a waiver of liability.
Physical Plant Basic Requirements	WAC's 388-76-10685 through 10795. Includes bedroom size and bedroom capacity, the need to follow all federal, state and local building codes, requirement for common use areas, the need for grab bars in the bathroom, adequate water temperatures, adequate facility temperature, adequate water supply, window size, and safety and maintenance requirements

List of all citation categories for FY 2011

Adult Family Home	FY2011
Chapter Description	Total Citations
Abuse	528
Abuse, punishment, seclusion	
Administration-General	1533
Adult family home provider, resident manager	
Adult family homes	
Advocacy, access, and visitation rights	
Basic Training	13
Care and Services	718
Competency Training	
Continuing Education	411
CPR and First Aid Training	147
Criminal History Background Check	662
Curriculum Approval	
Department authority to take actions in response to noncompliance	
Disaster and Emergency Prepardness	526
Disclosure of fees and notice requirements	1
Disclosure, transfer, and discharge requirements	15
Facility's policy on accepting medicaid as a payment source	1
Fire Drill Plan for Emergency Evacuation	566
Fire Protection	328
Food Services	120
Granting or Denying a License	36
Health Care Decision Making	108
Infection Control and Communicable Disease	59
Inspections--Complaint Investigations--Monitoring Visits	13
Instructor Approval	
License	176
License	1
License Application	87
Long-term Caregiver training	
Management Agreements	
Medical Devices and Restraints	356
Modified Basic Training	7
Negotiated Care Plan	1671
Notice of rights and services	6
Nurse Delegation Core Training	28
Orientation	298
Personal property	
Physical Plant Basic Requirements	1483
Privacy and confidentiality of personal and medical records	
Protection of resident's funds	1
Qualifications of Individuals Providing Care and Services	470
Quality of Life	97
Quality of Life	1
Remedies	44

Required training and continuing education	1
Chapter Description	**Total Citations**
Resident Advocate Access	1
Resident Asssessment	554
Resident Medications	3124
Resident Protection Program	
Resident Records	391
Resident Rights	2499
Residential Care Administrator Training	4
Rights are minimal	
Specialty Care	25
Specialty Training	310
Toll-free telephone number for complaints	
Tuberculosis Screening	527
Grand Total	**17947**

Adult Family Home

FY2010
Top 5 citation categories with description

FY2010 Citation Category	Description
Administration-General	WAC's 388-76-10191 through 10230. This category covers general administration of the home including Liability insurance coverage, ensuring enough staff are in the home and readily available to meet client needs, personnel records, following the terms and conditions of a Medicaid contract, protection of resident funds, and reporting requirements for abuse, neglect, abandonment or exploitation of a resident
Negotiated Care Plan	WAC's 388-76-10355 through 10385. Includes the requirement to develop a plan of care for a resident within 30 days of admission and the timeframes for updates to the plan of care. Also covers requirements for who is involved in the plan and who signs the plan of care
Resident Medications	WAC's 388-76-10430 through 10490 Includes expectations of a system for medication delivery and monitoring, Documentation of medications resident refusal of medication, medication administration levels (from independence to total assist with medications), altering of medication (crushing or cutting pills), appropriate use of medication organizers, and policies for appropriate disposal of unused medication
Resident Rights	WAC's 388-76-10510 through 10615 Includes resident right to exercise civil and legal rights, and receive notice of his/her rights. The right to notice of all services and charges for the services, the right to know about the staff in the home, the right to privacy, voice grievances, have visitors, and have access to advocates, the right to personal space and storage, the right to telephone and mail privacy. The right to a safe and orderly discharge (if the discharge is appropriate). The right not to sign a waiver of liability.
Physical Plant Basic Requirements	WAC's 388-76-10685 through 10795. Includes bedroom size and bedroom capacity, the need to follow all federal, state and local building codes, requirement for common use areas, the need for grab bars in the bathroom, adequate water temperatures, adequate facility temperature, adequate water supply, window size, and safety and maintenance requirements

List of all citation categories for FY 2010

Adult Family Home	FY2010
Chapter Description	**Total Citations**
Abuse	320
Abuse, punishment, seclusion	
Administration-General	909
Adult family home provider, resident manager	1
Adult family homes	1
Advocacy, access, and visitation rights	1
Basic Training	56
Care and Services	744
Competency Training	
Continuing Education	519
CPR and First Aid Training	185
Criminal History Background Check	771
Curriculum Approval	
Department authority to take actions in response to noncompliance	
Disaster and Emergency Preparedness	490
Disclosure of fees and notice requirements	1
Disclosure, transfer, and discharge requirements	8
Facility's policy on accepting medicaid as a payment source	26
Fire Drill Plan for Emergency Evacuation	517
Fire Protection	401
Food Services	158
Granting or Denying a License	8
Health Care Decision Making	174
Infection Control and Communicable Disease	48
Inspections--Complaint Investigations--Monitoring Visits	41
Instructor Approval	
License	186
License	
License Application	36
Long-term Caregiver training	
Management Agreements	
Medical Devices and Restraints	507
Modified Basic Training	5
Negotiated Care Plan	1658
Notice of rights and services	1
Nurse Delegation Core Training	14
Orientation	430
Personal property	
Physical Plant Basic Requirements	1448
Privacy and confidentiality of personal and medical records	
Protection of resident's funds	1
Qualifications of Individuals Providing Care and Services	541
Quality of Life	
Quality of Life	104
Remedies	51

Required training and continuing education	2
Chapter Description	**Total Citations**
Resident Advocate Access	1
Resident Assessment	632
Resident Medications	2739
Resident Protection Program	
Resident Records	368
Resident Rights	1216
Residential Care Administrator Training	1
Rights are minimal	
Specialty Care	5
Specialty Training	103
Toll-free telephone number for complaints	
Tuberculosis Screening	632
Grand Total	**16058**

Assisted Living Facility

FY2014
Top 5 citation categories with description

FY2014 Citation Category	Description
Assessment and Monitoring	WAC's 388-78A-2060 through 2120 includes: admission, qualified assessor, on-going, resident participation, monitoring.
Administration-Staff	WAC's 388-78A-2450 through 2489 includes: Quality assurance committee, background checks, training, Tuberculosis.
Negotiated Service Agreement	WAC's 388-78A-2600 includes: policies and procedures
Medications	WAC's 388-78A-2130 through 2160 includes: service agreement, negotiated, signed, implemented.
Administration-Safety and Disaster Preparedness	WAC's 388-78A-2210 through 2290 includes: services, authorizations, non-availability, alteration, storing, resident controlled, organized, family assistance.

List of all citation categories for FY 2014

Assisted Living Facility	FY2014
Chapter Description	Total Citations
Abuse, punishment, seclusion	2
Administration-Administrator	49
Administration-Building	359
Administration-Disclosure	2
Administration-Infection Control	88
Administration-Inspections, Enforcement Remedies, and Appeals	18
Administration-Licensing	100
Administration-Management Agreements	
Administration-Policies and Procedures	90
Administration-Reporting Requirements	190
Administration-Resident Rights	215
Administration-Safety and Disaster Preparedness	386
Administration-Specialized Training	17
Administration-Staff	570
Adult Day Services	
Advocacy, access, and visitation rights	2
All Contracted Residential Care Services	3
Applicability	5
Assessment and Monitoring	666
Assistance with activities of daily living	1
Assisted Living Services	4
Basic Training	15
Boarding Home Services	9
Continuing Education	92
Correction of violation/deficiency	
CPR and First Aid Training	46
Curriculum Approval	2
Definitions	1
Dementia Care	17
Department response to noncompliance or violations	1
Disclosure of fees and notice requirements	16
Disclosure, transfer, and discharge requirements	125
Enhanced Adult Residential Care	5
Examination of survey or inspection results	5
Exercise of rights	7
Facility's policy on accepting medicaid as a payment source	10
Food	276
Food handling	
General	15
General responsibility for each resident	2
Grievances	21
Home-based Training	3
Instructor Approval	1
Intent--Basic rights	1
Intermittent Nursing Services	172

Chapter Description	Total Citations
Issuance of food worker cards -- Fees	1
Mail and telephone	1
Management and personnel	1
Medications	407
Modified Basic Training	
Negotiated Service Agreement	462
Notice of rights and services	23
Nurse Delegation Core Training	3
Orientation	17
Personal property	1
Privacy and confidentiality of personal and medical records	4
Protection of resident's funds	
Public health labeling	
Purpose and authority	
Quality of life	54
Resident Records	106
Resident rights	
Residential Care Administrator Training	
Respite	2
Restraints	
Restricted Egress	13
Rules, regulations, and standards	
Specialty Training	77
Validity and form of food worker cards	3
Waiver of liability and resident rights limited	7
Water, plumbing, and waste	
Withdrawal from medicaid program	14
Grand Total	**4805**

Assisted Living Facility

FY2013
Top 5 citation categories with description

FY2013 Citation Category	Description
Assessment and Monitoring	WAC's 388-78A-2060 through 2120 includes: admission, qualified assessor, on-going, resident participation, monitoring.
Administration-Staff	WAC's 388-78A-2450 through 2489 includes: QA, background checks, training, TB
Administration-Safety and Disaster Preparedness	WAC's 388-78A-2600 includes: policies and procedures
Negotiated Service Agreement	WAC's 388-78A-2130 through 2160 includes: service agreement, negotiated, signed, implemented.
Medications	WAC's 388-78A-2210 through 2290 includes: services, authorizations, non-availability, alteration, storing, resident controlled, organized, family assistance.

List of all citation categories for FY 2013

Assisted Living Facility	FY 2013
Chapter Description	**Total Citations**
Abuse, punishment, seclusion	5
Administration-Administrator	23
Administration-Building	373
Administration-Disclosure	5
Administration-Infection Control	133
Administration-Inspections, Enforcement Remedies, and Appeals	17
Administration-Licensing	89
Administration-Management Agreements	
Administration-Policies and Procedures	82
Administration-Reporting Requirements	171
Administration-Resident Rights	234
Administration-Safety and Disaster Preparedness	455
Administration-Specialized Training	19
Administration-Staff	581
Adult Day Services	
Advocacy, access, and visitation rights	1
All Contracted Residential Care Services	6
Applicability	1
Assessment and Monitoring	656
Assistance with activities of daily living	
Assisted Living Services	6
Basic Training	12
Boarding Home Services	13
Continuing Education	9
Correction of violation/deficiency	1
CPR and First Aid Training	55
Curriculum Approval	
Definitions	
Dementia Care	28
Department response to noncompliance or violations	
Disclosure of fees and notice requirements	8
Disclosure, transfer, and discharge requirements	38
Enhanced Adult Residential Care	7
Examination of survey or inspection results	5
Exercise of rights	8
Facility's policy on accepting medicaid as a payment source	3
Food	251
Food handling	1
General	12
General responsibility for each resident	
Grievances	20
Home-based Training	
Instructor Approval	1
Intent--Basic rights	3
Intermittent Nursing Services	228

Chapter Description	Total Citations
Issuance of food worker cards -- Fees	1
Mail and telephone	1
Management and personnel	2
Medications	436
Modified Basic Training	3
Negotiated Service Agreement	459
Notice of rights and services	21
Nurse Delegation Core Training	
Orientation	15
Personal property	
Privacy and confidentiality of personal and medical records	6
Protection of resident's funds	1
Public health labeling	1
Purpose and authority	1
Quality of life	70
Resident Records	132
Resident rights	
Residential Care Administrator Training	3
Respite	2
Restraints	
Restricted Egress	10
Rules, regulations, and standards	1
Specialty Training	71
Validity and form of food worker cards	22
Waiver of liability and resident rights limited	4
Water, plumbing, and waste	
Withdrawal from medicaid program	12
Grand Total	**4834**

Assisted Living Facility

FY2012
Top 5 citation categories with description

FY2012 Citation Category	Description
Assessment and Monitoring	WAC's 388-78A-2060 through 2120 includes: admission, qualified assessor, on-going, resident participation, monitoring.
Administration-Staff	WAC's 388-78A-2450 through 2489 includes: QA, background checks, training, TB
Administration-Safety and Disaster Preparedness	WAC's 388-78A-2600 includes: policies and procedures
Negotiated Service Agreement	WAC's 388-78A-2130 through 2160 includes: service agreement, negotiated, signed, implemented.
Medications	WAC's 388-78A-2210 through 2290 includes: services, authorizations, non-availability, alteration, storing, resident controlled, organized, family assistance.

List of all citation categories for FY 2012

Assisted Living Facility	FY2012
Chapter Description	Total Citations
Abuse, punishment, seclusion	2
Administration-Administrator	54
Administration-Building	380
Administration-Disclosure	9
Administration-Infection Control	59
Administration-Inspections, Enforcement Remedies, and Appeals	40
Administration-Licensing	169
Administration-Management Agreements	
Administration-Policies and Procedures	103
Administration-Reporting Requirements	177
Administration-Resident Rights	221
Administration-Safety and Disaster Preparedness	487
Administration-Specialized Training	13
Administration-Staff	607
Adult Day Services	
Advocacy, access, and visitation rights	2
All Contracted Residential Care Services	7
Applicability	4
Assessment and Monitoring	857
Assistance with activities of daily living	
Assisted Living Services	3
Basic Training	32
Boarding Home Services	35
Continuing Education	35
Correction of violation/deficiency	
CPR and First Aid Training	50
Curriculum Approval	
Definitions	
Dementia Care	11
Department response to noncompliance or violations	
Disclosure of fees and notice requirements	9
Disclosure, transfer, and discharge requirements	83
Enhanced Adult Residential Care	5
Examination of survey or inspection results	3
Exercise of rights	7
Facility's policy on accepting medicaid as a payment source	1
Food	294
Food handling	2
General	23
General responsibility for each resident	
Grievances	16
Home-based Training	2
Instructor Approval	1
Intent--Basic rights	1
Intermittent Nursing Services	193

Chapter Description	Total Citations
Issuance of food worker cards -- Fees	
Mail and telephone	4
Management and personnel	
Medications	421
Modified Basic Training	9
Negotiated Service Agreement	529
Notice of rights and services	20
Nurse Delegation Core Training	2
Orientation	65
Personal property	
Privacy and confidentiality of personal and medical records	7
Protection of resident's funds	1
Public health labeling	
Purpose and authority	
Quality of life	75
Resident Records	153
Resident rights	1
Residential Care Administrator Training	5
Respite	
Restraints	1
Restricted Egress	12
Rules, regulations, and standards	
Specialty Training	79
Validity and form of food worker cards	1
Waiver of liability and resident rights limited	3
Water, plumbing, and waste	
Withdrawal from medicaid program	16
Grand Total	**5401**

Assisted Living Facility

FY2011
Top 5 citation categories with description

FY2011 Citation Category	Description
Applicability	WAC's 388-78A-2010 through 2050 is the General section which includes: license required, not required, disclosure to non-residents, resident characteristics; and other federal, state, county, and municipal rules, codes, ordinances
Administration-Staff	WAC's 388-78A-2450 through 2489 includes: Quality assurance committee, background checks, training, Tuberculosis.
Orientation	WAC's 388-112-0015 through 0035 includes: orientation, long term care, and facility safety training.
Administration-Safety and Disaster Preparedness	WAC's 388-78A-2600 includes: policies and procedures
Negotiated Service Agreement	WAC's 388-78A-2130 through 2160 includes: service agreement, negotiated, signed, implemented.

List of all citation categories for FY 2011

Assisted Living Facility	FY2011
Chapter Description	Total Citations
Abuse, punishment, seclusion	4
Administration-Administrator	36
Administration-Building	286
Administration-Disclosure	7
Administration-Infection Control	51
Administration-Inspections, Enforcement Remedies, and Appeals	5
Administration-Licensing	117
Administration-Management Agreements	1
Administration-Policies and Procedures	130
Administration-Reporting Requirements	167
Administration-Resident Rights	261
Administration-Safety and Disaster Preparedness	501
Administration-Specialized Training	17
Administration-Staff	551
Adult Day Services	1
Advocacy, access, and visitation rights	3
All Contracted Residential Care Services	11
Applicability	1118
Assessment and Monitoring	13
Assistance with activities of daily living	
Assisted Living Services	24
Basic Training	38
Boarding Home Services	19
Continuing Education	40
Correction of violation/deficiency	
CPR and First Aid Training	1
Curriculum Approval	
Definitions	
Dementia Care	48
Department response to noncompliance or violations	
Disclosure of fees and notice requirements	21
Disclosure, transfer, and discharge requirements	106
Enhanced Adult Residential Care	7
Examination of survey or inspection results	1
Exercise of rights	5
Facility's policy on accepting medicaid as a payment source	
Food	239
Food handling	
General	1
General responsibility for each resident	
Grievances	22
Home-based Training	
Instructor Approval	
Intent--Basic rights	22
Intermittent Nursing Services	5

Chapter Description	Total Citations
Issuance of food worker cards -- Fees	
Mail and telephone	150
Management and personnel	
Medications	1
Modified Basic Training	1
Negotiated Service Agreement	394
Notice of rights and services	6
Nurse Delegation Core Training	
Orientation	516
Personal property	14
Privacy and confidentiality of personal and medical records	9
Protection of resident's funds	84
Public health labeling	
Purpose and authority	
Quality of life	1
Resident Records	5
Resident rights	3
Residential Care Administrator Training	100
Respite	137
Restraints	2
Restricted Egress	6
Rules, regulations, and standards	
Specialty Training	14
Validity and form of food worker cards	
Waiver of liability and resident rights limited	53
Water, plumbing, and waste	7
Withdrawal from medicaid program	5
Grand Total	**5387**

Assisted Living Facility

FY2010
Top 5 citation categories with description

FY2010 Citation Category	Description
Assessment and Monitoring	WAC's 388-78A-2060 through 2120 includes: admission, qualified assessor, on-going, resident participation, monitoring.
Administration-Staff	WAC's 388-78A-2450 through 2489 includes: Quality assurance committee, background checks, training, Tuberculosis.
Administration-Safety and Disaster Preparedness	WAC's 388-78A-2600 includes: policies and procedures
Negotiated Service Agreement	WAC's 388-78A-2130 through 2160 includes: service agreement, negotiated, signed, implemented.
Medications	WAC's 388-78A-2210 through 2290 includes: services, authorizations, non-availability, alteration, storing, resident controlled, organized, family assistance.

List of all citation categories for FY 2010

Assisted Living Facility	FY2010
Chapter Description	Total Citations
Abuse, punishment, seclusion	2
Administration-Administrator	56
Administration-Building	282
Administration-Disclosure	6
Administration-Infection Control	46
Administration-Inspections, Enforcement Remedies, and Appeals	12
Administration-Licensing	58
Administration-Management Agreements	
Administration-Policies and Procedures	112
Administration-Reporting Requirements	167
Administration-Resident Rights	199
Administration-Safety and Disaster Preparedness	549
Administration-Specialized Training	12
Administration-Staff	628
Adult Day Services	7
Advocacy, access, and visitation rights	1
All Contracted Residential Care Services	5
Applicability	6
Assessment and Monitoring	909
Assistance with activities of daily living	
Assisted Living Services	7
Basic Training	34
Boarding Home Services	27
Continuing Education	15
Correction of violation/deficiency	
CPR and First Aid Training	41
Curriculum Approval	
Definitions	
Dementia Care	22
Department response to noncompliance or violations	
Disclosure of fees and notice requirements	10
Disclosure, transfer, and discharge requirements	115
Enhanced Adult Residential Care	19
Examination of survey or inspection results	3
Exercise of rights	2
Facility's policy on accepting medicaid as a payment source	
Food	183
Food handling	
General	23
General responsibility for each resident	
Grievances	10
Home-based Training	
Instructor Approval	
Intent--Basic rights	3
Intermittent Nursing Services	194

Chapter Description	Total Citations
Issuance of food worker cards -- Fees	
Mail and telephone	1
Management and personnel	
Medications	416
Modified Basic Training	14
Negotiated Service Agreement	459
Notice of rights and services	15
Nurse Delegation Core Training	
Orientation	149
Personal property	1
Privacy and confidentiality of personal and medical records	5
Protection of resident's funds	4
Public health labeling	
Purpose and authority	
Quality of life	67
Resident Records	122
Resident rights	1
Residential Care Administrator Training	5
Respite	5
Restraints	3
Restricted Egress	9
Rules, regulations, and standards	
Specialty Training	62
Validity and form of food worker cards	
Waiver of liability and resident rights limited	1
Water, plumbing, and waste	1
Withdrawal from medicaid program	11
Grand Total	**5116**

Certified Community Residential Services and Supports

FY2014
Top 5 citation categories with description

FY2014 Citation Category	Description
4160: Mandated reporting to law enforcement	388-101-4160, Service provider must report to law enforcement when there is reason to suspect that the client was sexually or physically assaulted, or when there are concerning injuries, or at the client or guardians request. .
3320: Client rights	388-101-3320, The client has the right to be free from harm including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment and financial exploitation.
3860: Positive behavior support plan	388-101-3860, Service provider must develop, train to and implement a written individualized positive support plan when a client takes psychotropic medications or has restrictive procedures including physical restraints.
3360: Client services	388-101-3360, Service providers must provide each client with instruction and support as appropriate for activities to include, but not be limited to, home living, community living, health and safety, social and life-long learning, and employment.
3370: Client health services support	388-101-3370, Service providers must provide instruction and/or support as identified to include, but not limited to, accessing medical and dental services, medication management, arranging health care appointments, monitoring medical treatment prescribed by health professionals and communicating directly with health professionals when needed.

List of all citation categories for FY 2014

Certified Community Residential Services and Supports	FY2014
Chapter Description	**Total Citations**
3020: Compliance	0
3150: State and federal access to program	1
3160: Plan of correction	1
3190: Service provider responsibilities.	0
3200: Staffing requirements.	3
3220: Administrator responsibilities and training	1
3240: Policies and procedures	7
3250: Background checks—Requirements for service providers	5
3255: Background checks—Provisional hire—Pending results.	1
3320: Client rights	17
3330: Treatment of clients.	4
3360: Client services	9
3370: Client health services support	7
3372: Medical devices.	0
3375: Nurse delegation.	0
3390: Physical and safety requirements.	4
3420: Client refusal to participate in services	0
3440: Changes in client service needs—Emergent	1
3470: Development of the individual instruction and support plan	0
3500: Accessibility of the individual instruction and support plan	1
3510: Ongoing updating of the individual instruction and support plan.	0
3520: Shared expenses and client related funds	0
3530: Individual financial plan	0
3540: Managing client funds	0
3550: Reconciling and verifying client accounts.	0
3580: Client financial records.	0
3590: Transferring client funds.	1
3610: Client reimbursement	1
3630: Medication services—General	6
3630: Medication services—General.	6
3640: Medication—Types of support	0
3660: Medication assistance.	0
3670: Medication administration—Nurse delegation.	1
3700: Storage of medications.	1
3720: Medications—Documentation	1
3800: Retention of client records	1
3820: Client's property records	0
3850: Functional assessment.	4
3860: Positive behavior support plan	10
3870: Client protection	1
3900: Restrictive procedures approval.	0
3970: Community protection—Approval	0
3980: Community protection—Policies and procedures	2
4000: Community protection—Staff training	0
4010: Community protection—Treatment plan	1
4030: Community protection—Client transportation	0
4150: Mandated reporting to the department	0
4160: Mandated reporting to law enforcement	18
4170: Mandated reporting policies and procedures	3
Grand Total	**119**

Certified Community Residential Services and Supports

FY2013
Top 5 citation categories with description

FY2013 Citation Category	Description
3320: Client rights	388-101-3320, The client has the right to be free from harm including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment and financial exploitation
4150: Mandated reporting to the department	388-101-4150, Service provider must report to the state complaint hotline when there is reasonable cause to believe a client was abandoned, abused, neglected, financially exploited, or sexually assaulted.
3860: Positive behavior support plan	388-101-3860, Service provider must develop, train to and implement a written individualized positive support plan when a client takes psychotropic medications or has restrictive procedures including physical restraints.
4160: Mandated reporting to law enforcement	388-101-4160,Service provider must report to law enforcement when there is reason to suspect that the client was sexually or physically assaulted, or when there are concerning injuries, or at the client or guardians request. .
3250: Background checks—Requirements for service providers	388-101-3250, Background checks must be obtained for all administrators, employees, volunteers, students and subcontractors-upon hire, and then every three years. The provider must prevent the individual from unsupervised access to clients if the background check shows a disqualifying conviction or pending criminal charge under 388-113 (WAC).

List of all citation categories for FY 2013

Certified Community Residential Services and Supports	FY 2013
Chapter Description	**Total Citations**
3020: Compliance	0
3150: State and federal access to program	0
3160: Plan of correction	1
3190: Service provider responsibilities.	2
3200: Staffing requirements.	1
3220: Administrator responsibilities and training	1
3240: Policies and procedures	3
3250: Background checks—Requirements for service providers	7
3255: Background checks—Provisional hire—Pending results.	2
3320: Client rights	26
3330: Treatment of clients.	2
3360: Client services	4
3370: Client health services support	3
3372: Medical devices.	0
3375: Nurse delegation.	0
3390: Physical and safety requirements.	2
3420: Client refusal to participate in services	0
3440: Changes in client service needs—Emergent	0
3470: Development of the individual instruction and support plan	1
3500: Accessibility of the individual instruction and support plan	0
3510: Ongoing updating of the individual instruction and support plan.	0
3520: Shared expenses and client related funds	2
3530: Individual financial plan	0
3540: Managing client funds	1
3550: Reconciling and verifying client accounts.	1
3580: Client financial records.	1
3590: Transferring client funds.	0
3610: Client reimbursement	0
3630: Medication services—General	5
3630: Medication services—General.	5
3640: Medication—Types of support	1
3660: Medication assistance.	0
3670: Medication administration—Nurse delegation.	1
3700: Storage of medications.	1
3720: Medications—Documentation	2
3800: Retention of client records	0
3820: Client's property records	0
3850: Functional assessment.	2
3860: Positive behavior support plan	17
3870: Client protection	1
3900: Restrictive procedures approval.	0
3970: Community protection—Approval	0
3980: Community protection—Policies and procedures	1
4000: Community protection—Staff training	1
4010: Community protection—Treatment plan	1
4030: Community protection—Client transportation	0
4150: Mandated reporting to the department	19
4160: Mandated reporting to law enforcement	12
4170: Mandated reporting policies and procedures	1
Grand Total	**130**

Certified Community Residential Services and Supports

FY2012
Top 5 citation categories with description

FY2012 Citation Category	Description
3320: Client rights	388-101-3320, The client has the right to be free from harm including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment and financial exploitation.
4150: Mandated reporting to the department	388-101-4150, Service provider must report to the state complaint hotline when there is reasonable cause to believe a client was abandoned, abused, neglected, financially exploited, or sexually assaulted.
3860: Positive behavior support plan	388-101-3860, Service provider must develop, train to and implement a written individualized positive support plan when a client takes psychotropic medications or has restrictive procedures including physical restraints.
3630: Medication services—General.	388-101-3630, Service provider must ensure medications are given as ordered and in a manner that safeguards the client's health and safety.
4160: Mandated reporting to law enforcement	388-101-4160,Service provider must report to law enforcement when there is reason to suspect that the client was sexually or physically assaulted, or when there are concerning injuries, or at the client or guardians request. .

List of all citation categories for FY 2012

Certified Community Residential Services and Supports	FY2012
Chapter Description	**Total Citations**
3020: Compliance	3
3150: State and federal access to program	2
3160: Plan of correction	0
3190: Service provider responsibilities.	2
3200: Staffing requirements.	1
3220: Administrator responsibilities and training	3
3240: Policies and procedures	3
3250: Background checks—Requirements for service providers	8
3255: Background checks—Provisional hire—Pending results.	0
3320: Client rights	40
3330: Treatment of clients.	6
3360: Client services	4
3370: Client health services support	6
3372: Medical devices.	4
3375: Nurse delegation.	2
3390: Physical and safety requirements.	4
3420: Client refusal to participate in services	1
3440: Changes in client service needs—Emergent	1
3470: Development of the individual instruction and support plan	2
3500: Accessibility of the individual instruction and support plan	1
3510: Ongoing updating of the individual instruction and support plan.	1
3520: Shared expenses and client related funds	2
3530: Individual financial plan	2
3540: Managing client funds	2
3550: Reconciling and verifying client accounts.	2
3580: Client financial records.	1
3590: Transferring client funds.	0
3610: Client reimbursement	2
3630: Medication services—General	12
3630: Medication services—General.	12
3640: Medication—Types of support	0
3660: Medication assistance.	1
3670: Medication administration—Nurse delegation.	0
3700: Storage of medications.	1
Grand Total	189

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

FY2014
Top 5 citation categories with description

FY2014 Citation Category	Description
STAFF TREATMENT OF CLIENTS	Federal Tags: W149, W153, W154-Failure to report allegations of abuse and neglect in a timely manner. Failure to investigate allegations thoroughly. Facility failed to develop and implement policies regarding client protections.
PHYSICIAN SERVICES	Federal Tags: W322 Facility must provide preventative and general medical care to include assessment and treatment of acute and chronic conditions...and referral to specialists.
PROGRAM MONITORING & CHANGE	Federal Tags: W257 thru 263, A Specially Constituted Committee must review, approve and monitor all restrictive client programs to include physical restraints, restrictions and psychotropic medications. A Qualified Intellectual Disability Professional must also monitor and revise a client's Active Treatment plan when the client is regressing, losing skills or failing to progress.
EVACUATION DRILLS	Federal Tag: W440 thru W450, Drills occur each shift and once per quarter. Drills are held under varied conditions including varied time frames and exit locations. All drills are evaluated. Clients are physically evacuated at least once per year, per shift (versus mock evacuation).
INDIVIDUAL PROGRAM PLAN	Federal Tag: W227 Individual Program plan must have objectives for the needs that are identified in the client's comprehensive assessment and are considered to be most likely to improve the client's ability to function independently.

List of all citation categories for FY 2012

Intermediate Care Facilities for Individuals with Intellectual Disabilities	FY2014
Chapter Description	**Total Citations**
ACTIVE TREATMENT	1
CLIENT BATHROOMS	
CLIENT RECORDS	1
COMMUNICATION WITH CLIENTS, PARENTS &	
COMPLIANCE W FEDERAL, STATE & LOCAL LAWS	3
CONDUCT TOWARD CLIENT	1
DINING AREAS AND SERVICE	1
DIRECT CARE STAFF	1
DRUG ADMINISTRATION	3
DRUG REGIMEN REVIEW	1
DRUG STORAGE AND RECORDKEEPING	
DRUG USAGE	2
EVACUATION DRILLS	4
FLOORS	
FOOD AND NUTRITION SERVICES	1
GOVERNING BODY	2
INDIVIDUAL PROGRAM PLAN	4
INFECTION CONTROL	3
MEAL SERVICES	
MENUS	1
MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	
NURSING SERVICES	
PHYSICIAN SERVICES	7
PROFESSIONAL PROGRAM SERVICES	
PROGRAM DOCUMENTATION	1
PROGRAM IMPLEMENTATION	3
PROGRAM MONITORING & CHANGE	6
PROTECTION OF CLIENTS RIGHTS	3
QUALIFIED MENTAL RETARDATION PROFESSIONAL	1
SERVICES PROVIDED WITH OUTSIDE SOURCES	
STAFF TRAINING PROGRAM	1
STAFF TREATMENT OF CLIENTS	8
Grand Total	**59**

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

FY2013
Top 5 citation categories with description

FY2013 Citation Category	Description
PROGRAM MONITORING & CHANGE	Federal Tags: W257 thru 263, A Specially Constituted Committee must review, approve and monitor all restrictive client programs to include physical restraints, restrictions and psychotropic medications. A Qualified Intellectual Disability Professional must also monitor and revise a client's Active Treatment plan when the client is regressing, losing skills or failing to progress.
NURSING SERVICES	Federal Tags: W336 Nursing Assessments must be done quarterly.
STAFF TREATMENT OF CLIENTS	Federal Tags: W153 -Failure to report allegations of abuse and neglect in a timely manner.
GOVERNING BODY	Federal Tags: W262 and W263-The Specially Constituted Committee must review, approve and monitor all restrictive programs. Each restrictive program must be conducted with a written consent.
PHYSICIAN SERVICES	Federal Tags: W322, Facility must provide preventative and general medical care to include assessment and treatment of acute and chronic conditions...and referral to specialists.

List of all citation categories for FY 2013

Intermediate Care Facilities for Individuals with Intellectual Disabilities	FY 2013
Chapter Description	**Total Citations**
ACTIVE TREATMENT	
CLIENT BATHROOMS	1
CLIENT RECORDS	1
COMMUNICATION WITH CLIENTS, PARENTS &	
COMPLIANCE W FEDERAL, STATE & LOCAL LAWS	2
CONDUCT TOWARD CLIENT	1
DINING AREAS AND SERVICE	
DIRECT CARE STAFF	2
DRUG ADMINISTRATION	1
DRUG REGIMEN REVIEW	2
DRUG STORAGE AND RECORDKEEPING	2
DRUG USAGE	
EVACUATION DRILLS	3
FLOORS	1
FOOD AND NUTRITION SERVICES	1
GOVERNING BODY	4
INDIVIDUAL PROGRAM PLAN	2
INFECTION CONTROL	4
MEAL SERVICES	3
MENUS	1
MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	1
NURSING SERVICES	7
PHYSICIAN SERVICES	4
PROFESSIONAL PROGRAM SERVICES	1
PROGRAM DOCUMENTATION	1
PROGRAM IMPLEMENTATION	1
PROGRAM MONITORING & CHANGE	13
PROTECTION OF CLIENTS RIGHTS	3
QUALIFIED MENTAL RETARDATION PROFESSIONAL	1
SERVICES PROVIDED WITH OUTSIDE SOURCES	1
STAFF TRAINING PROGRAM	2
STAFF TREATMENT OF CLIENTS	6
Grand Total	**72**

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

FY2012
Top 5 citation categories with description

FY2012 Citation Category	Description
STAFF TREATMENT OF CLIENTS	Federal Tags: W149 - Facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.
EVACUATION DRILLS	Federal Tag: W440 Drills occur each shift and once per quarter.
PROGRAM MONITORING & CHANGE	Federal Tags: W263, A Specially Constituted Committee must review, approve and monitor all restrictive client programs to include physical restraints, restrictions and psychotropic medications. A Qualified Intellectual Disability Professional must also monitor and revise a client's Active Treatment plan when the client is regressing, losing skills or failing to progress.
CONDUCT TOWARD CLIENT	Federal Tags: W269 Client should be afforded the right to daily decision making to include choice of meals, clothing and daily activity.
DRUG ADMINISTRATION	Federal Tags: W368 All drugs administered without errors and following doctor's orders.

List of all citation categories for FY 2012

Intermediate Care Facilities for Individuals with Intellectual Disabilities	FY2012
Federal Tag - Chapter Description	**Total Citations**
ACTIVE TREATMENT	
CLIENT BATHROOMS	
CLIENT RECORDS	
COMMUNICATION WITH CLIENTS, PARENTS &	1
COMPLIANCE W FEDERAL, STATE & LOCAL LAWS	
CONDUCT TOWARD CLIENT	2
DINING AREAS AND SERVICE	1
DIRECT CARE STAFF	
DRUG ADMINISTRATION	2
DRUG REGIMEN REVIEW	
DRUG STORAGE AND RECORDKEEPING	
DRUG USAGE	
EVACUATION DRILLS	4
FLOORS	1
FOOD AND NUTRITION SERVICES	
GOVERNING BODY	2
INDIVIDUAL PROGRAM PLAN	2
INFECTION CONTROL	
MEAL SERVICES	
MENUS	
MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	1
NURSING SERVICES	
PHYSICIAN SERVICES	
PROFESSIONAL PROGRAM SERVICES	
PROGRAM DOCUMENTATION	
PROGRAM IMPLEMENTATION	
PROGRAM MONITORING & CHANGE	3
PROTECTION OF CLIENTS RIGHTS	2
QUALIFIED MENTAL RETARDATION PROFESSIONAL	
SERVICES PROVIDED WITH OUTSIDE SOURCES	
STAFF TRAINING PROGRAM	1
STAFF TREATMENT OF CLIENTS	10
Grand Total	**32**

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

- Fircrest School Statement of Deficiencies (SODs) 2015 - 2010

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600
June 4, 2015

BY FACSIMILE and CERTIFIED MAIL (7007 1490 0003 4195 0284)

Important Notice – Please Read Carefully

Jeff Flesner, Interim Superintendent
Fircrest School PAT A
15230 – 15th Avenue NE
Shoreline, Washington 98155

RE: Recertification Survey 5/11/2015 through 5/21/2015
Complaint Investigation: 3033540

Dear Mr. Flesner:

From 5/11/2015 through 5/21/2015 survey staff from the Residential Care Services (RCS) Division of the Aging and Disability Services Administration (ADSA) conducted a recertification survey and complaint investigation at your facility. Based on that survey and investigation, RCS determined that Fircrest School PAT A is out of compliance with three of the federal condition of participation (COP) requirements for ICFs/IID participating in the Medicaid Title XIX ICF/IID program. Compliance with all COPs, found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The recertification survey and complaint investigation completed on 5/21/2105, found that Fircrest School PAT A failed to comply with the following COPs:

W102 CFR 483.410 – Governing Body and Management

Specifically, the following governing body requirement was found not met:

W104 CFR 483.410(a)(1) exercise general operating direction over the facility

W122 CFR 483.420 – Client Protections

Specifically, the following client protection requirements were found not met:

W125 CFR 483.420(a)(3) Exercise rights as clients and citizens
W153 CFR 483.420(d)(2) Allegations reported immediately
W154 CFR 483.420(d)(3) Alleged violations are thoroughly investigated

W195 CFR 483.440 – Active Treatment

Specifically, the following active treatment requirements were found not met:

W196 CFR 483.440(a)(1) Each client receives active treatment
W247 CFR 483.440(c)(6)(vi) Client choice and self management
W250 CFR 483.440(d)(2) Active Treatment Schedules
W255 CFR 483.440(f)(1)(i) Revise plan when an objective achieved
W257 CFR 483.440(f)(1)(iii) Revise plan when an objective is not being achieved
W258 CFR 483.440(f) (1)(iv) Consider new training objectives
W448 CFR 483.470(i)(2)(iv) Investigate all problems with evacuation drills

The deficiencies are described in CMS Form 2567, a copy of which is attached. The cited deficiencies indicate limitations in Fircrest School PAT A capacity to provide adequate operating direction, protection of clients, and active treatment services to clients. Significant corrections will be required before the facility can be found to be in compliance.

Remedy
Substantial compliance with federal requirements must be achieved and verified by 8/19/2015 (90 days from the date on which the survey was completed (SOM 3012)). Failure to achieve substantial compliance with 42 CFR 483.410 Governing Body, 42 CFR 483.420 Client Protections, and 42 CFR 483.440 Active Treatment may result in termination from the Medicaid ICF/IID program (42 CFR 442.101 (3) (e); SOM 3005 E).

Alternate Remedy
In lieu of termination from the Medicaid program, the State Medicaid Agency (SMA) may choose to impose a Denial of Payments for New Admissions (42 CFR 442.118; SOM 3006). If the SMA chooses to impose the denial of payment remedy, you will be notified on or before the 60th day, 7/20/2015, and will be advised of any appeal rights at that time.

Plan of Correction (POC)
At this time you may voluntarily submit a POC, however, the POC will not halt the termination proceedings. The department will proceed with termination until you have achieved substantial compliance with the Conditions of Participation (CoPs). The COPs must be verified on-site by RCS as substantially implemented by 8/19/2015. At the time you achieve substantial compliance with the COP, you will be required to submit an acceptable POC for any remaining standard level deficiencies. If and when you do submit a POC, it must be approved by RCS.

An acceptable POC must contain at a minimum the following core elements (SOM 3006.5):

1. How the corrective action will be accomplished for the sample Individuals found to have been affected by the deficient practice;

2. How the facility will identify other Individuals who have the potential to be affected by the same deficient practice, and how it will act to protect Individuals in similar situations;

3. What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;

4. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and

5. When corrective action will be accomplished.

Allegation of Compliance

When you believe the CoP deficiencies have been corrected, please provide the ICF/IID Quality Assurance Administrator with a written credible allegation of compliance. The credible allegation should address the deficiencies cited under 42 CFR 483.410 - W102 Governing Body, 42 CFR 483.420 - W122 Client Protections, and 42 CFR 483.440 - W195 Active Treatment. The letter should describe: (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur.

If Fircrest School PAT A makes a credible allegation of compliance, the ICF/IID survey team will revisit to determine whether compliance or acceptable progress has been achieved. Only two revisits are permitted, one no later than 7/2/2015 (within 45 days of the date on which the survey was completed and before the holiday weekend), and one between 7/6/2015 and 8/19/2015 (between the 46th and 90th days (SOM 3012)). The compliance decision by RCS needs to be finalized no later than 8/19/2015 (90th day). RCS will require at least five working days to complete a credible allegation survey and make a decision regarding compliance. Please plan accordingly if you want RCS to be able to complete a credible allegation survey before 8/19/2015(90th day).

If upon the subsequent revisit, your facility has not achieved substantial compliance, the termination or denial of payment for new admissions will be imposed. A revisit will not be conducted if a letter of credible allegation is not received by RCS. The COP will need to be found to be in substantial compliance before certification can be continued.

Informal Dispute Resolution (IDR)

You may request an IDR of the deficiencies on which this action is based. RCS must receive your request for an IDR no later than 6/14/2015. To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a written credible allegation of compliance

within the time limits described above. The written IDR request should:

1) Identify the specific deficiencies that are disputed;
2) Explain why you are disputing the deficiencies; and
3) Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review)

If requested, an IDR will be scheduled. During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. The IDR process will not change the time frames stated in this letter, including the deadlines for achieving compliance and submitting a written credible allegation of compliance.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,

Gerald Heilinger, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services

Enclosure

cc: CMS Regional Office, Washington State ICF/IID Team
Bill Moss, Assistant Secretary of ALTSA
Kathy Morgan, Interim Director of RCS
Donna Cobb, Senior Counsel
Evelyn Perez, Assistant Secretary of DDA
Donald Clintsman, Deputy Assistant Secretary of DDA
Janet Adams, DDA Office Chief
Larita Paulsen, DDA QM Unit Manager
Bruce Work, DDA Medicaid Compliance Administrator

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600
June 22, 2015

Jeff Flesner, Interim Superintendent
Fircrest School PAT A
15230 – 15th Avenue NE
Shoreline, Washington 98155

RE: Recertification Survey 5/11/2015 through 5/21/2015
Complaint Investigation: 3033540

Dear Mr. Flesner:

Please find attached the amended SoD as discussed.

If you have any questions concerning the, please contact me at (360) 725-2405.

Sincerely,

Gerald Hellinger, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services

Enclosure

cc: CMS Regional Office, Washington State ICF/IID Team
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	50G053	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

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W 000	INITIAL COMMENTS This report is a result of the annual recertification survey conducted at Fircrest School from 5/11/15 through 5/21/15. In addition the following complaint investigation was included: 3033540. The survey team included: Gerald Hellinger, Kathy Heinz, Jim Tarr, and Ted Sparkuhl The surveyors are from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services; ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-3215 *The SOD was amended on 6/15/15: 1. Under W125 #4 references to Client #11 were removed and Client #3 was inserted. 2. Under W153 #6 references to wheelchair were replaced with chair. 3. Under W154 #7 references to wheelchair were replaced with chair. 4. Under W196 on page 27 in the second paragraph the reference to Client #2 was changed to Client #24.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 owing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 100	Continued From page 1 facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation (COP) for Active Treatment Services. Findings include: The facility did not meet the Condition of Participation (COP) for Active Treatment Services. The facility did not ensure Clients received continuous active treatment services that included aggressive and consistent implementation of formal and informal training programs and supports. Clients were observed spending significant blocks of time where no formal or informal training occurred. See W195.	W 100		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

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W 102	Continued From page 2 This CONDITION is not met as evidenced by: Based on observations, record review and interviews the facility failed to meet the Condition of Participation (COP) for Governing Body by not exercising operating direction over the facility by not meeting the COP for Active Treatment and the COP for Client Protection. Findings include: The governing body failed to exercise general operating direction by not developing and implementing habilitation plans based on functional assessments, by not promoting Client choice and self-management, by not ensuring allegations of abuse, neglect and mistreatment were reported to the State and not thoroughly investigating allegations of abuse, neglect and mistreatment. Findings include: W104, W106, W122, W195	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, it was determined the facility governing body failed to provide sufficient oversight to ensure that the functions of the facility Emergency Response Committee were implemented as described in the facility ' s Standard Operating Procedure (SOP) #I.A.13. The failure of the facility governing body to ensure oversight resulted in no quarterly drills occurring and no feedback given to emergency responders after real medical emergencies occurred.	W 104		

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W 104	Continued From page 3 Findings include: 1. Review on 5/13/15 of the facility " Medical Emergencies " SOP #1.A.13 revealed the facility Emergency Response Committee was responsible for reviewing documentation of how staff respond during medical emergency drills, including actions and times of arrival at the hypothetical scene. Interview on 5/14/15 with Staff X and Staff V revealed the Emergency Response Committee had not held a meeting for more than one year. Staff V and Staff X were unable to say when the last Emergency Response Committee met to review emergency response drills. 2. Review on 5/13/15 of the " Medical Emergencies " Standard Operating Procedure (SOP) #I.A.13 revealed emergency medical response drills were to be conducted on a quarterly basis by the Staff Development office and the Safety Officer. The facility was requested on 5/13/15 to provide documentary evidence to verify emergency medical response drills had been conducted on a quarterly basis. In response to this inquiry, Staff X stated that the facility had not conducted any emergency medical response drills since 1/30/14- more than 15 months ago. Interview with Staff V on 5/14/15 verified the facility did not have any documentation to show that emergency medical response drills had been conducted since 1/30/14.	W 104		
W 106	483.410(a)(3) GOVERNING BODY The governing body must appoint the administrator of the facility. This STANDARD is not met as evidenced by:	W 106		

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W 106	Continued From page 4 Based on record review and interview the governing body failed to comply with State law when they did not report allegations of abuse, neglect and mistreatment. This failure resulted in the State Agency not being aware of the allegations and therefore unable to conduct its ' own investigations to determine if Clients were safe. Findings include: See W153	W 106		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Clients ' rights were protected, when the facility obstructed Clients ' views from bedroom windows, removed personal property from a Client ' s bedroom without due process, and used Clients ' personal money to fund training programs. The facility also failed to ensure allegations of abuse, neglect and mistreatment were reported to the State Agency and incidents were thoroughly investigated. These failures resulted in Clients' rights being violated without due process and prevented the facility and the State Agency from knowing if Clients were being protected. Findings include: See W125, W126 , W153 and W154.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	W 125		

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W 125	Continued From page 5 Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure Clients' rights were protected when it used Clients' money to fund facility initiated programs, blocked views from bedroom windows, and removed personal property from a Client's bedroom without due process. These failures resulted in Clients living in bedrooms without being able to see outside, having to pay for programs the facility considered part of their habilitation, and having personal possessions removed because of their behavior without going through due process. Findings include: 1. Cooking Programs: a. Pizza Observation on 5/15/15 revealed a direct care staff had Staff N, from House 313/314 authorize the withdrawal of $10.00 from 13 Clients' personal accounts to pay for a cooking program. When asked what Clients were going to learn how to cook, staff did not know. Observation on 5/15/15 at noon revealed Staff A had purchased 9 pizzas from a local pizza franchise for 13 Clients using the Clients' personal money. Review of the receipt revealed the total cost was $95.90.	W 125		

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W 125	Continued From page 6 Interview on 5/20/15 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not aware of cooking programs at House 313/314. Interview with Staff O on 5/19/15 revealed the facility kitchen could furnish food for Clients to use for cooking programs so they don ' t have to use their personal money. b. Spaghetti Review of a cash withdraw slip dated 5/1/15 revealed Staff N had authorized staff to withdraw money from Clients ' accounts for a facility initiated cooking program. Review of the grocery store receipt dated 5/1/15 revealed Clients living in the home paid for spaghetti noodles, sauce, ground beef, onions, garlic bread and parmesan cheese. Total cost to the Clients was $102.94. Interview with Staff O on 5/20/15 revealed, kitchen staff did not deliver lunch trays to House 313/314 on Fridays. The surveyor showed the grocery store receipt dated 5/1/15 to Staff O. Staff O verified the items purchased by the Clients at the local grocery store could have been provided to the Clients by the facility kitchen at no cost to the Clients. c. Bar-B-Que Review of a cash withdrawal slip dated 5/6/15 revealed Staff N authorized Clients to spend their own money on a facility initiated cooking program. The Clients paid for boneless chicken, pork rib eye chops, sausages, chicken quarters, soda, Bar-B-Que sauce, spices, cheese, ice cream, hot dog buns, strawberries, grapes and candy. The total cost to Clients was $105.07. Interview on 5/19/15 with the QIDP revealed Clients living at House 313/314 did not have a cooking program, and that most of the Clients at	W 125		

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W 125	Continued From page 7 that house were unable to decide what to cook and had varying skills and levels of ability to cook. Interview on 5/19/15 with Staff O revealed most of the items purchased by the Clients could have been provided by the facility kitchen at no cost to the Clients. d. Sunday Bar-B-Que Review of a Cash Withdrawal receipt dated 5/14/15 revealed Staff N authorized the use of Clients ' money to pay for a Bar-B-Que. The Clients purchased lamb, chicken, soda, cookies, onions and hot peppers. The total cost Clients' spent for the Bar-B-Que was $133.14. Staff P was interviewed about the Bar-B-Que held every Sunday at House 313/314. Staff P stated that Staff eat the Bar-B-Que meal with the Clients. Staff P collects varying amounts of money from staff working at the home during the Bar-B-Que. He stated that some staff don ' t always have money to pay for the food. Staff P used money staff contributed to pay for additional food. He stated food is laid out on a table on the patio and everyone helps themselves. 2. Observation on 5/18/15 revealed Client #9 worked in the Adult Training Program (ATP) area of the facility tearing labels off empty medication bubble packs. Review of the trust fund account ledger dated 4/1/15 to 4/30/15 revealed Client #9's wages for working were deposited into his personal account. Review on 5/20/15 of an Implementation Plan for Vending Machine dated May, 2015 revealed Client #9 had a formal program to place money in	W 125		

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W 125	Continued From page 8 a vending machine, select an item and hand his change (own money) back to the shift charge. Review of the trust account ledger dated 4/1/15 to 4/30/15 revealed Client #9 used his own money to pay for the facility initiated program. 3. Observation on 5/18/15 revealed Client #30 worked in the ATP area of the facility tearing labels off used medication bubble packs. Review on 5/15/15 of the ATP Fund Piece Rate dated 4/1/15 to 4/30/15 revealed Resident #30 earned money at ATP and one of the jobs she was paid to do included tearing labels off used medication bubble packs. Review on 5/20/15 of a Money Management Program dated May, 2015 revealed Resident #30 had a training program to learn how to make a purchase at a store. Data was collected by staff on 5/1/15, 5/5/15, 5/7/15, 5/12/15 and 5/14/15. Interview on 5/15/15 with Staff R and the trust account records present, revealed Client #30 used her own money to pay for facility initiated programs. 4. Review on 5/18/15 of Client #3 ' s file revealed an Addendum to Program dated 5/12/15 stated: " If he engages in property destruction and is at risk we will remove all items and clothing out of his room to keep [Client #3 's first name] and other peers safe". There was no abridgement of Client #3's rights in his file related to his belongings being removed from his possession. Interview on 5/19/15 with the QIDP assigned to Client #3 verified there was no abridgement of	W 125		

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W 125	Continued From page 9 rights for removing property. She stated it was still in the Human Rights Committee review process and probably wouldn ' t be reviewed until the next month. She verified the removal of property was being implemented currently. She revealed she did not see this as a restriction for Client #3. 5. Observation on 5/11/15 of Client #31 ' s bedroom window at House [redacted] revealed it had opaque window film extending up approximately five feet from the bottom of the window. Review on 5/20/15 of Client #31 ' s file revealed there was no abridgement of rights for this restriction. Interview on 5/20/15 with Staff T verified there was no abridgement. 6. Observation on 5/11/15 of Client #32 ' s bedroom window revealed it had opaque window film covering the entire window. Review on 5/20/15 of Client #32 ' s file revealed there was no abridgement of rights for this restriction. Interview on 5/20/15 with Staff T verified there was no abridgement. 7. Observation on 5/11/15 of Client #33 ' s bedroom window at House [redacted] revealed it had opaque window film covering approximately the bottom third of the window. Review on 5/20/15 of Client #33 ' s record revealed there was no abridgement of rights for this restriction. Interview on 5/20/15 with Staff S verified there was no abridgement of Client #33 ' s rights for the window covering.	W 125		

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W 125	Continued From page 10 8. Observation on 5/12/15 of Client #34 ' s bedroom window at House [redacted] revealed the bedroom window had an opaque window film covering over the entire window. Interview on 5/20/15 with the QIDP assigned to Client #34 verified there was no abridgement of rights for the window covering restriction. 9. Observation on 5/12/15 of Client #16 ' s bedroom window at House [redacted] revealed the bedroom window had a frosted window film covering the entire window. Interview on 5/20/15 with the QIDP assigned to Client #16 verified there was no abridgement of rights for the window covering restriction. 10. Observation on 5/12/15 of Client #4 ' s bedroom window at House [redacted] revealed the bedroom window had a frosted window film with [redacted] covering the entire window. Interview on 5/20/15 with the QIDP assigned the Client #4 verified there was no abridgement of rights for the window covering restriction. 11. Observation on 5/12/15 of Client #35 ' s bedroom window at House [redacted] revealed the bedroom window had a frosted window film covering to approximately six feet from the bottom of the window. Interview on 5/20/15 with the QIDP assigned to Client #35 verified there was no abridgement of rights for the window covering restriction. 12. On 5/11/15 at 1:54 PM Client #27 while in the day room at House [redacted] was observed to remove one of his shoes and throw it towards a staff. Staff J told another staff that when Client #27 throws his shoe he is restricted from having it	W 125		

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W 125	Continued From page 11 back for five minutes. Staff J stated that the shoe restriction was implemented by Client #27 ' s Adult Training Program (ATP) staff. On 5/12/15 at 11:06 AM Client #27 was observed to throw his shoe at Staff I in the ATP workroom. Staff I tried to block Client #27 from picking up his shoe. A record review of Client #27 ' s Comprehensive Functional Assessment and Individual Habilitation Plan dated 8/27/14 did not identify any need to restrict Client #27 from his shoe if he threw it. A record review on 5/21/15 could find no authorization for the abridgement of rights for Client #27 allowing staff to restrict him from his shoe if he threw it. Interviews on 5/19/15 with the QIDP assigned to Client #27 and Staff D revealed that there was no program that restricted Client #27 from his shoe for five minutes if he threw it. An interview on 5/21/15 with Staff E and Staff G also revealed there was no authorized shoe restriction implemented for Client #27.	W 125		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on a Task 2 review of the facility ' s system to prevent abuse, neglect or mistreatment, it was determined the facility failed to ensure that allegations of abuse neglect and	W 153		

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FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

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W 153	Continued From page 12 mistreatment were reported to the Department of Social and Health Services Complaint Resolution Unit. Failure to report allegations of abuse, neglect and mistreatment to the CRU prevents the State Agency from ensuring that Clients are safe. Findings include: Record review of the following incidents revealed they were not reported to the CRU in accordance with state law: 1. On 5/6/15 at approximately 10 AM, Expanded Sample Client #16 was punched on the left side of the head by another Client and the right side of her head was knocked into a cabinet. She was startled and said her head hurt. 2. On 4/25/15 while he was doing his laundry, Expanded Sample Client #15 was hit in the back by another Client. Client #15 yelled briefly. 3. On 4/25/15 while on a van ride, Expanded Sample Client #17 was grabbed by a peer from behind his seat and sustained 2 scratches on the right side of his neck. 4. On 2/12/15 at 5:10 PM in the #301 dining room, Expanded Sample Client #19 was pushed backwards by a peer, causing Client #19 to fall to the floor and hit the back of her head on the door frame. Client #19 cried loudly. 5. On 4/17/15 at 6:55 PM, a peer came from behind Expanded Sample Client #20, grabbed her shirt and scratched Client #20 ' s right shoulder. Client #20 became upset and engaged in self injurious behavior by biting her right hand	W 153		

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W 153	Continued From page 13 and leaving a red mark. 6. On 3/26/15 at 12:15 pm in the cafeteria, Expanded Sample Resident #21 tripped over a chair and fell to the cafeteria floor in the presence of staff. As a result of the fall she sustained a displaced fracture of the [redacted] which required transport to the community hospital for treatment. 7. On 4/21/15 at approximately 11 AM, direct care staff received a report that an unknown male person was observed looking into Expanded Sample Client #23 ' s bedroom window while Client #23 was standing naked in her bedroom. A second allegation was made that Client #23 ' s assigned 1:1 staff person was not attending to this Client ' s needs and permitted her to remain naked in her room with the door open while maintenance staff were present in the main living room.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on a review of facility incident report investigations it was determined the facility failed to ensure that all allegations of abuse, neglect and mistreatment were thoroughly investigated. Failure to investigate all aspects of incidents prevented the facility from knowing exactly what happened and to develope effective corrective actions. Findings include:	W 154		

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W 154	Continued From page 14 Review of the following incidents revealed they did not include a thorough investigation: 1. On 4/25/15, while he was doing his laundry, Expanded Sample Client #15 was hit in the back by another Client. Client #15 yelled briefly. The facility investigation did not include evidence as to why Client #15 was hit, where staff were when this incident occurred, or what could be done to prevent the incident from occurring again in the future. 2. On 5/6/15 at approximately 10 am, Expanded Sample Client #16 was punched on the left side of the head by another Client which caused her to hit the right side of her head into a cabinet. She was startled and said her head hurt. The facility investigation did not analyze what staff could have done differently to prevent the peer from punching Client #16. The investigation lacked any specificity that would have explained the antecedents or why two staff, who were present, were unable to prevent Client #16 from being punched. 3. On 4/25/15 while on a van ride, Expanded Sample Client #17 was aggressed against by a peer from behind his seat and sustained two scratches on the right side of his neck. The facility investigation failed to identify any antecedents and whether there were any trends of altercations between Client #17 and the peer. 4. On 3/2/15 at approximately 3:30 PM, a peer followed Expanded Sample Client #12 outside of the house and shoved her backwards, causing her to cry out and lose her balance. The facility investigation did not explain why the peer	W 154		

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W 154	Continued From page 15 followed her, where staff were located at the time of the incident, how staff reacted to the incident, if staff were following the supervision guidelines, if there were any trends of altercations between these Clients or if modifications of the environment were needed. 5. On 2/12/15 at 5:10 PM in the #301 dining room, Expanded Sample Client #19 was pushed backwards by a peer, causing Client #19 to fall to the floor and hit the back of her head on the door frame. Client #19 was crying loudly, saying " she pushed me." The facility did not investigate this incident to determine why the peer pushed Client #19 to the floor, where staff were located when the incident occurred and why staff were unable to prevent it. 6. On 4/17/15 at 6:55 pm, a peer came from behind Expanded Sample Client #20, grabbed her shirt and scratched her right shoulder. Client #20 reacted to the incident by becoming upset and engaged in self injurious behavior by biting her right hand and leaving a red mark. The facility investigation did not determine why the peer aggressed against Client #20, whether staff had the opportunity to position themselves to prevent the attack, whether there were antecedents prior to the incident, if there were previous altercations between these two Clients, or any discussion of recommendations to prevent future attacks. 7. On 3/26/15 at 12:15 PM in the cafeteria, Expanded Sample Client #21 tripped over a chair and fell to the cafeteria floor. As a result of the fall she sustained a displaced fracture of the [redacted] which required transport to the community hospital for treatment. The facility investigation did not review why Client #21 tripped over the	W 154		

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W 154	Continued From page 16 chair, whether staff were assisting her at the time of the fall or whether staff should have been at her side to safely assist her in the cafeteria. 8. On 4/28/15 at 3:45 pm, Expanded Sample Client #22 was found with a 2 " x 1 " bruise on his right forearm. Staff reported the injury occurred at the local public school. The facility did not follow-up with the school to determine how the injury occurred, whether Client #22 accidentally injured himself or if it was the result of an altercation with somebody at school.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that three of 13 Sample Clients (Clients #3, #11, and #12) and two Expanded Sample Clients (#25 and #26) had Qualified Intellectual Disabilities Professional (QIDP) who actively developed a plan which met the Client ' s needs, actively monitored the plan for success, coordinated the correct implementation of the plan, and advocated for the Clients ' needs. Failure to have QIDPs who fulfill their responsibilities puts the Clients at risk of not receiving the services they need to become more independent and move to a less restrictive setting. Findings include:	W 159		

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W 159	Continued From page 17 1. Observations of Client #3 during the survey from 5/11/15 through 5/19/15 revealed Client #3 spent a lot of time in his bedroom. He frequently refused to participate in activities offered by the staff. He did not attend a work training program. During all observations of Client #3, the QIDP was not observed to be directly involved with him or the staff providing his treatment. Review on 5/18/15 of Client #3 ' s file revealed the QIDP had noted that he had not made progress on his skill training programs from September, 2014 through March, 2015. No changes to these programs were noted. Interview on 5/19/15 with the QIDP assigned to Client #3 verified no changes had been made to the programs despite the lack of progress. The QIDP stated staff were to attempt to get Client #3 to attend ATP. The QIDP revealed Client #3 ' s mother/guardian made demands of the facility regarding her son which prevented the facility from working to help him be more independent. 2. Observations of Client #11 during the survey from 5/11/15 through 5/19/15 revealed Client #11 spent a lot of time where she was not engaged in any meaningful activity. Staff were observed occasionally handing her a magazine, which she did not look at, or occasionally they attempted to get her engaged with a child ' s toy which was not appropriate for a woman almost [redacted] years of age. During all of the observations of Client #11, the QIDP was not observed to be involved with her or the staff providing her treatment. Review on 5/20/15 of Client #11 ' s file revealed the facility had determined she should receive training on seven different basic care skills. For the year of 2014, Client #11 had made no progress on six of these skills and on the seventh she had passed the criteria for success each month, but the QIDP	W 159		

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W 159	Continued From page 18 had not made any changes to the programs. Interview on 5/20/15 with the QIDP verified she had made no changes to Client #11 ' s programs for over a year. 3. Observation made from 5/11/15 to 5/18/15 at both the homes and Adult Training Program revealed Client #12, Client #25 and Client #26 not consistently involved in meaningful activities or training. In addition on 5/14/15 a staff was observed denying Client #12 additional food at dinner because the staff believed Client #12 had a dietary restriction. A record review on 5/18/15 found a Consent for dietary restrictions for Client #12 that was not signed by her legal guardian. The guardian wrote on the consent that she believed the dietary restriction for Client #12 was on hold because Client #12 had lost weight. However Client #12 ' s 6/12/14 Individual Habilitation Plan (IHP) indicated that she was on an 1800 calorie a day diet. A record review for Client #25 ' s IHP dated 5/28/14 indicated that Client #25 willingly engages in most work tasks. It also indicated that Client #25 has difficulty with unstructured time and staff to plan and offer activities. A record review for Client #26 ' s IHP dated 8/20/14 indicated that Client #26 had mastered the shredding program and is sampling a variety of alternative vocational task. The CFA also indicated that Client #26 enjoyed work. The QIDP was interviewed on 5/19/15 and reported that the IHPs for Clients #12 and #25 needed to be revamped because the training programs no longer fit the clients. In addition the	W 159		

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W 159	Continued From page 19 QIDP reported there was no longer any dietary restriction for Client #12. The QIDP also reported that the IHP for Client #26 needed to be modified for Client #26 due to her age and physical disabilities.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews it was determined that the facility failed to ensure that medical emergency response staff participated in regularly scheduled medical emergency response drill training to prepare them for actual medical emergencies. Failure of the facility to ensure that medical emergency responders received regular documented training on medical emergency scenarios prevented the responders from having the opportunity to practice and refine their skills and ability to respond to real medical emergencies and puts Clients at risk should a medical emergency occur. Findings include: Review on 5/12/15 of Expanded Sample Client #14 's death revealed he experienced a cardiac event at 5:55 am the morning of [redacted]15. Staff found him unresponsive, not breathing and without a pulse. Staff announced a medical emergency via internal facility phone system and called 911. Staff immediately began cardio-pulmonary resuscitation (CPR) efforts to	W 189		

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W 189	Continued From page 20 revive him. Facility staff responded to the emergency with emergency medical equipment including a portable Automatic External Defibrillator (AED). Though the cardiac emergency met the criteria for connecting the resident to the AED to determine if the heart rhythm was compatible for an electric shock to the heart, the AED was not used. Community emergency medical staff (EMS) arrived on the scene at approximately 6:05 am and continued resuscitation efforts. At 6:40 am, EMS pronounced Client #14 deceased. At the time of EMS arrival, facility staff had been administering CPR for approximately 10 minutes. The facility conducted a Mortality Review Meeting (MRM) on 2/17/15 to review, 1) the quality of care Client #14 received prior to the medical emergency, and 2) the quality of the facility ' s immediate response to the medical emergency. The MRM noted the following: A. Facility emergency staff failed to hook up Client #14 to the AED to ascertain if the heart rhythm was compatible with AED use. B. The facility emergency team needs to bring in the AED during these types of medical emergencies as a regular course of action. C. Facility medical emergency responders needed to have refresher courses on AED. D. The facility needed to reinstitute emergency response drills. Review on 5/13/15 of the " Medical Emergencies " Standard Operating Procedure (SOP) #I.A.13 revealed medical emergency response drills were	W 189		

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W 189	Continued From page 21 to be conducted on a quarterly basis by the Staff Development office and the Staff X. The facility was requested on 5/13/15 to provide documentary evidence to verify medical emergency response drills had been conducted on a quarterly basis. In response to this inquiry, the Staff X stated that there had not been any medical emergency response drills since 1/30/14, more than 15 months ago. Interview with Staff V on 5/14/15 verified the facility did not have any documentation to show that medical emergency response drills had been conducted since 1/30/14. A number of recommendations were made at Client 14 ' s 2/17/15 Mortality Review Meeting with the goal of improving the quality of the facility ' s response to medical emergencies. Since the date of that meeting more than 3 months have passed and the facility has yet to conduct and document medical emergency response drill training incorporating the transport and use of an AED.	W 189		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to develop and implement systems that resulted in Clients receiving consistently implemented plans based on functionally assessed needs which was then monitored by a Qualified Intellectual Disabilities Professional for any changes which might be	W 195		

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W 195	Continued From page 22 needed. Clients were not consistently encouraged to make choices for themselves and to manage their daily activities to the fullest extent possible. This failure prevented the Clients from receiving necessary services and supports to promote greater autonomy and independence and resulted in the Condition of Participation of Active Treatment Services to be not met. Findings include: See W196; W247, W250, W255, W257, W258	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure three of 13 Sample Clients (Clients #3, #11, and #12,) and three Expanded Sample Clients (Clients #24, #25, #26) received a continuous, consistently implemented program of supports, services, and training to meet their needs. Failure to ensure Clients were provided active treatment prevented them from acquiring skills to increase their independence. Findings include:	W 196		

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W 196	Continued From page 23 1. Observation at House 314 on 5/12/15 between 8:45 AM and 9:30 AM revealed Client #24 was sitting in a chair by a window twirling a set of black and white strings. At 9:25 AM Staff M asked him if he wanted to look at a magazine. This was the only interaction from staff. Resident #24 rejected the magazine and continued to twirl the string. Client #24 was not engaged in any meaningful activity. On 5/12/15 while walking by house 314 at 11:10 AM and again at 11:55 AM the surveyor observed Client #24 sitting in a chair by a window twirling strings. Observation on 5/12/15 between 2:25 PM and 3:57 PM revealed Client #24 was sitting in a chair. A staff asked Client #24 if he wanted something to eat. Client #24 followed the staff into the kitchen. Client #24 grabbed the staff's waist. The staff asked Client #24 if he "could dance." Client #24 grabbed the staff around the neck and the staff said "space please." Client #24 then laid his head on the staff's shoulder and the staff stated, "that ' s nice". Client #24 then made "raspberry" noises with his lips. Staff made Client #24 a peanut butter sandwich. Client #24 sat down at the kitchen table and started yelling, screaming, making growling like noises while he ate his peanut butter sandwich. Client #24 stood up from the table, walked to the dining room window started yelling, screaming and making growling like noises. Staff asked Client #24 if he could help clean up the table. Client #24 screamed and shook his head "no." Client #24 sat at the kitchen table and made growling like noises, yelled and screamed for half an hour. Staff did not encourage any meaningful activity.	W 196		

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W 196	Continued From page 24 Informal interview with a direct care staff revealed Client #24 preferred to eat alone. Observation on 5/13/15 between 7:10 AM and 8:05 AM revealed Client #24 sat on his bed, in his underwear, with the door open, yelling, and making growling like noises. Interview with the graveyard staff indicated Client #24 was protesting something staff asked him to do and that Client #24 has "moods." Staff periodically walked past his room and asked him if he was OK. Observation on 5/13/15 at 8:55 AM revealed Client #24 was sitting on his bed yelling, and making growling like noises. At 9:11 AM, Staff A went into the bedroom and assisted Client #24 to get dressed. At 9:15 AM Client #24 stood in the hallway by his room, yelled, screamed and made growling like noises. At 9:30 AM Client #24 walked to the living area of the home holding one pant leg up with one hand, and twirling a string in the other. Staff working in the home encouraged Client #24 to dance. Staff chanted "go [name of Client #24] y", "go [name of Client #24]y". Staff A was sitting in an office chair in the middle of the living area. Client #24 sat briefly on the staff's lap. Staff A pushed him off. Client #24 hugged Staff A and twirled the chair Staff A was sitting in. Staff continued to encourage Client #24 to dance and twirl the chair Staff A was sitting in. Client #24 danced around the room holding one pant leg up with one hand and a string in the other. Staff did not engage Client #24 in any meaningful activity. Observation on 5/13/15 at 9:50 AM revealed Client #24 was sitting in a chair by a window twirling strings. At 10:00 AM, Client #24 got up from the chair and walked to the patio, holding one pant leg up with one hand and twirling a	W 196		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 25 string in the other. His pants were observed to be on backwards. Client #24 came back into the living area of the home. At 10:10 AM Staff B was sitting on the arm of a couch. Client #24 sat on her lap. Staff B assisted him off her lap. Client #24 pinched Staff B in the breast area. Staff B stated "safe hands" to Client #24. Observation on 5/13/15 at 1:25 PM revealed Client #24 was sitting in a chair on the porch. A direct care staff approached Client #24 and said "hi". Client #24 yelled at the staff and tossed the strings at the staff. The direct care staff tossed the strings back at Client #24. Client #24 ran into the kitchen holding the strings in one hand. Client #24 pinched Staff A's bottom and kicked at Staff A. Client #24 stuck his tongue up to his nose and staff laughed. Staff A redirected Client 24 out of the kitchen. Client #24 covered his mouth with his hand and made "raspberry" like noises. Staff did not engage Client #24 in any meaningful activity. Observation on 5/14/15 between 9:40 AM and 10:20 AM revealed Client #24 stood looking out the window by the side door of the home or in the dining area of the home. Direct care stated to Client #24 "are you looking for the school bus? It's already passed by." Client #24 was not engaged in any meaningful activity. Observation on 5/14/15 at 11:55 AM revealed Client #24 was sitting in a chair by the window located by a side door of the home. He appeared to be sleeping. Informal interview with a staff revealed a staff went to get a lunch tray for Client #24 because Client #24 would not eat in the cafeteria with other Clients. At 12: 20 PM a staff asked Client #24 when he wanted to eat lunch.	W 196		

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W 196	Continued From page 26 Client #24 rubbed his eyes and made a growling like noise. Observation on 5/14/15 between 2:10 PM and 2:30 PM revealed Client #24 was sitting in a chair by a window located by the side door of the house. A staff conducting an investigation said "hi" to Client #24. That was the only interaction from staff. Observation on 5/14/15 between 2:40 PM and 3:30 PM revealed client #24 was sitting in a chair by the window located by the side door of the house. A direct care staff said "hi" to Client #24, and asked him if he wanted to listen to music. Client #24 twirled a string he was holding. Client #24 stood up, sat down and threw the string at the staff. Staff tossed the string back to Client #24. Staff working in the home continued to encourage Client #24 to get up and dance. Client #24 danced around the living area of the home holding one pant leg up with one hand and a string in the other. Client #24 pinched a staff's bottom and Client #28 stated "he is trying to get your booty." Client #28 laughed. Client #24 made raspberry noises with his lips. Client #28 stated to Client #24 "shake it like a salt shaker." Client #28 stated "look, [name of Client #24] is trying to back it up into you." A direct care staff wiggled the string in Client #24's face. Client #24 sat on the couch and put his bottom up in the air and held his legs open with his hands. Staff did not engage Client #24 in any meaningful activity. Observation on 5/15/15 at 8:25 AM revealed Client #24 was sitting in a chair by a window located by a side door of the home. Client #24 threw the strings at the surveyor. The surveyor put the strings on the counter. After a few	W 196		

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W 196	Continued From page 27 minutes, Staff K observed the strings on the counter and handed them to Client #24. Interview with Staff K on 5/15/15 regarding the strings revealed "the strings are a leisure activity and not a program." Interview with Staff K on 5/15/15 regarding the activity of dancing revealed Client #24 liked to dance and it was a leisure activity. At 8:40 AM Client #24 was observed sitting at the dining room table twirling a string. At 8:55 AM, Client #24 was observed sitting in a chair by a window located by a side door to the home twirling a string. Staff did not engage Client #24 in any meaningful activity. Observation on 5/15/15 at 11:30 AM revealed Client #24 sat either in the chair located by the side door of the home or in the dining room. At noon he was observed in the chair by the side door of the home twirling strings in his hand. He was not engaged in any meaningful activity. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/20/15 regarding Client #24 ' s active treatment plan and the surveyors observations revealed, Client #24 " does not do anything". 2. Observation on 5/11/15 from 3:05 PM to 3:25 PM revealed Client #11 was in her home at House [redacted] sitting on a couch holding a torn up magazine. At 3:19 PM she laid down on the couch and a staff tried to get her to sit up but was unsuccessful. No other staff interaction occurred during the observation. Observation on 5/12/15 from 10:00 AM to 10:37 AM of Client #11 revealed she was sitting on a couch at House [redacted] Her feet were up on the couch. At 10:08 AM a staff took her to a shelf to	W 196		

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W 196	Continued From page 28 choose a magazine. Client #11 took a magazine back to the couch but did not look at it. At 10:14 AM a staff tried to get her to look at the magazine, but she resisted and the magazine was put back on the couch. At 10:18 AM a staff tried to get her to look at the magazine, but she just put it down on the couch. The staff gave her a different magazine which remained open on Client #11 ' s lap, but she did not look at it. The observation ended at 10:37 AM with Client #11 still on the couch. Observation on 5/12/15 at 2:27 PM of Client #11 at the facility ' s Senior Retirement Program revealed she was sitting on a couch. A staff was sitting with her attempting to get her to do a child ' s wooden non-interlocking piece puzzle by handing her a piece of the puzzle. At 2:34 PM a staff had her feel the texture of what appeared to be a " pool noodle ". At 2:42 PM the staff again attempted to get her to do the puzzle. The observation ended at 2:58 PM when the Clients left to go back to their house. Observation on 5/13/15 at House [redacted] at 9:32 AM revealed Client #11 was walking around and then went and sat down on a couch. At 9:45 AM she walked up to a staff who got her a magazine and then led her back to a couch where she sat down. At 9:50 AM a staff brought a pan of soapy appearing water to the couch and assisted Client #11 to put her feet into the water for a brief period of time. The staff then dried her feet and rubbed lotion on them and put her shoes and sox back on her. The staff did not train Client #11 to do any of this activity. The observation ended at 10:14 AM. Observation on 5/15/15 at House [redacted] at 10:02	W 196		

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W 196	Continued From page 29 AM revealed Client #11 was sitting on a couch with her feet up holding a book, which she was not looking at. At 10:05 AM staff brought her to a table to " paint rocks ". She was given colored construction paper and markers. It required hand over hand assistance for Client #11 to use the materials. The observation ended at 10:38 AM with Client #11 sitting on the couch. Observation on 5/18/15 at House [redacted] at 3:33 PM revealed Client #11 was sitting in a chair. At 3:54 PM she got up and walked into the dining room. A staff brought her back and assisted her to wash her hands. Client #11 then went back to the chair and sat down. The observation ended at 3:58 PM with Client #11 still sitting in the chair. Review on 5/20/15 of Client #11 ' s file revealed her IHP dated 6/9/14 noted: " Across all domains, the challenge is to increase [Client #11 ' s first name] participation ". There were no programs or strategies which directly addressed this fundamental challenge for Client #11. Interview on 5/20/15 with the QIDP assigned to Client #11 verified she was not making progress on her Individual Habilitation Plan (IHP) objectives and that no changes had been made in her programs. 3. On 5/12/15 from 9:58 AM to 10:34 AM Client #12 was observed at her workstation in the Adult Training Program (ATP) workroom for House 301/302. Client #12 had a wooden paper folder device in front of her. During the observation Client #12 only folded the sheet of paper when a staff placed the paper in the folding device. As soon as staff walked away from Client #12 she would pick up a wooden box and stare at the	W 196		

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W 196	Continued From page 30 bottom of the box. The majority of the time was spent not engaged in a meaningful activity. On 5/14/14 from 5:25 PM to 5:50 PM Client #12 was observed in House [redacted]. At 5:25 PM Client #12 exited the dining room after eating dinner and went down the hallway towards her bedroom. At 5:34 PM Client #12 was observed in her bedroom topless with the bedroom door open. No staff had checked on her. At 5:50 PM Client #12 was still in her bedroom and no staff had gone to check on her. On 5/15/15 from 10:09 AM to 11:01 AM Client #12 was observed at her workstation in the ATP workroom for House [redacted]. From 10:09 AM to 10:18 AM Client #12 was seated at her workstation not involved in a work activity. At 10:19 AM a staff placed a piece of paper in the paper folding device and Client #12 folded it. Client #12 continued to fold paper but only when the staff put the piece of paper in the folding device and cued Client #12 to fold it. At 10:45 AM Client #12 returned to her workstation after a break. Client #12 stared at a wooden box until 10:54 AM when Staff F placed a piece of paper in the folding device and cued Client #12 to fold it. At 10:55 AM Client #12 picked up wooden box of papers and dumped it out. At 10:58 AM a staff returned to Client #12 and placed a paper in the folding device and cued her to fold the paper. Client 12 never folded a piece of paper without staff being involved. A record review on 5/19/15 of Client #12 ' s ATP Vocational Assessment indicated that she needed prompting in the workshop but could work independently for short periods of time. Client #12 ' s Choice Implementation Plan revised in	W 196		

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W 196	Continued From page 31 November 2013 indicated that Client# 12 would chose her work activity by pointing to a communication board. No such board was observed being used. The QIDP was interviewed on 5/19/15 regarding Client #12 and reported that he was aware that Client #12 ' s IHP was coming due for review and that her program needed to be revamped because it no longer fit Client #12 ' s needs. 4. On 5/12/15 from 10:11 AM to 10:34 AM Client #25 was observed in the ATP workroom for House [redacted] At 10:11 AM Client #25 slid out of her chair at her workstation to the floor on her right side. Staff Q knelt down and spoke with Client #25. Over the next 23 minutes she continued to lie on the floor and periodically Staff Q asked her if she wanted to get up. At 10:34 AM Staff Q and Staff F helped Client #25 back into her chair. An interview with Staff Q revealed that this was not an uncommon behavior for Client #25. The staff are instructed to ask Client #25 if she wanted to get up and to sign if she wanted something to drink. During this observation she was not engaged in any meaningful activity. On 5/14/14 from 10:38 AM to 11:31 AM Client #25 was observed sitting at her workstation in the ATP workroom for House [redacted] At 10:53 AM and 10:58 AM Staff Q asked Client #25 if she would like to work. Client #25 continued to sit at her workstation. At 11:07AM Staff Q moved Client #25 ' s chair closer to her workstation not engaged in a meaningful activity. Client #25 pushed herself back from workstation. At 11:11 AM Staff F pushed Client #25 closer to her	W 196		

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W 196	Continued From page 32 workstation she pushed herself back and turned sideways to her workstation. At 11:15 AM Staff F asked Client #25 if she was working. Client #25 touched a newspaper and then pulled her hand back. At 11:19 AM Client #25 sat leaning forward. At 11:21 AM Staff Q signed to Client #25 if she wanted to work. There was no reaction from Client #25. At 11:25 AM Staff Q handed Client #25 a newspaper and she handed it back. At 11:30 AM Client #25 remained seated at her workstation not engaged in any meaningful activity. On 5/14/15 from 4:27 PM to 5:50 PM Client #25 was observed in the dayroom at House [redacted]. At 4:27 PM Client #25 sat in front of the television. At 4:29 PM Client #25 opened a book and looked at it. At 4:42 PM Client #25 continued to sit in the dayroom. Some of the other Clients entered the dining room to begin dinner. At 4:47 PM Client #25 was still sitting in the dayroom. At 5:00 PM a staff asked Client #25 if she would like to eat dinner. There was no reaction from Client #25 who was still not engaged in any meaningful activity. At 5:04 PM a staff asked Client #25 if she is going to eat. She indicated no. At 5:17 PM Client #25 still sat in the dayroom. At 5:41 PM Staff F asked Client #25 if she was going to eat and positioned her walker in front of her. Client #25 pushed the walker away with her foot. At 5:40 PM a staff tried to get Client #25 to go to dinner. He told her she could have ice cream later. Client #25 did not move. The observation ended with Client #25 still not engaged in any activity. On 5/15/15 from 10:11 AM to 11:01 AM Client #25 was observed at her workstation in the ATP workroom for House [redacted]. At 10:24 AM Client	W 196		

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W 196	Continued From page 33 #25 sat sideways at her workstation. At 10:38 AM Client #25 slid down to the floor on her right side. At 10:39 AM Client #25 got up to her knees in an attempt to get up from the floor. She hit herself in the face and then sat down on her chair. At 10:47 AM Client #25 sat in her chair and stared across the room. At 10:55 AM Client #25 still sat in her chair without any activity. At 10:56 AM Client #25 picked up a newspaper and opened it. A staff scooted her closer to her workstation. At 11:00 AM Staff Q gave Client #25 a newspaper to open but Client #25 did not react. At 11:01 AM Client #25 continued to sit alone. During the observation Client #25 did not engage in any meaningful activity. On 5/18/15 from 2:10 PM to 3:12 PM Client #25 was observed sitting in a chair in the living room at House [redacted] not involved in any activity. At 2:39 PM Client #25 was observed in a different chair in the living room putting items in a basket. At 3:12 PM Client #25 was observed sitting on the couch in the living room not involved in any activities. A record review for Client #25 ' s IHP dated 5/28/14 indicated that Client #25 willingly engaged in most work tasks. It also indicated that Client #25 has difficulty with unstructured time and staff are expected to plan and offer meaningful activities. The QIDP and Staff D were interviewed on 5/19/15 regarding Client #25. The QIDP reported that he was aware that Client #25 ' s IHP was coming due for review and that her program needed to be revamped because it no longer fit Client #25 ' s needs. 5. On 5/11/15 from 2:02 PM to 2:17 PM Client	W 196		

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W 196	Continued From page 34 #26 was observed sitting in a chair in the dining room of House [redacted] looking out the window. No staff approached her. Staff J reported that Client #26 enjoys looking out the window. On 5/12/15 from 10:50 AM to 11:41 AM Client #26 was observed sitting at her workstation in the ATP workroom for House [redacted] Client #26 had a stack of newspapers that she was supposed to fold. Several attempts were made by staff to get Client #26 to fold the newspaper. Each time Client #26 refused. Client #26 just sat in her chair. At 11:13 AM Client #26 got up from her chair and left the workroom. She returned to her chair a couple of minutes later. At 11:24 AM the QIDP assigned to Client #26 took Client #26 to the bathroom. She returned at 11:28 AM. Client #26 continued to sit in her chair until the group left for the coffee shop at 11:58 AM. Client #26 was not engaged in any meaningful activity at her workstation during the observation. On 5/13/15 from 7:26 AM to 8:48 AM Client #26 was observed in House [redacted] At 7:26 AM Client #26 returned to the dining room after having finished dinner and gone to the bathroom. A staff positioned a chair by the window in the dining room and Client #26 sat down and looked out the window. At 8:05 AM a staff asked Client #26 if she would like to join the group in the living room or continue sitting in the chair. Client #26 stayed in her chair. At 8:06 AM Client #26 moved the chair so she could look into the kitchen. At 8:22 AM Staff F asked Client #26 what she would like to do. Client #26 got up briefly from the chair but returned to the chair at 8:24 AM. Client #26 was still seated in a chair in the dining room when the observation concluded at 8:48 AM.	W 196		

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W 196	Continued From page 35 On 5/18/15 from 10:15 AM to 11:23 AM Client #26 was observed sitting in the dining room of House [redacted] staring out the window or into the kitchen. At 10:30 AM Staff I walked Client #26 to the bathroom and then back to the chair in the dining room where Client #26 sat until the end of the observation at 11:23 AM. A record review for Client #26 ' s IHP dated 8/20/14 indicated that Client #26 had mastered the shredding program and was sampling a variety of alternative vocational tasks. The IHP also indicated that Client #26 enjoyed work. The QIDP, Staff D and Staff R were interviewed on 5/19/15 regarding Client # 26. The QIDP reported that he would like to see Client #26 go to a recreation program because she was aging and had some physical disabilities. 6. Observation on 5/12/15 at House [redacted] revealed Client #3 was in his bedroom playing with a keyboard. At 10:50 AM a staff told him there was some stuff going on out in the other room, but Client #3 refused to come out. At 10:58 AM a staff brought some games to Client #3 ' s room and offered him the opportunity to play. He refused. At 11:19 AM he was offered the opportunity to do a floor puzzle, but he refused. The observation ended at 11:21 AM with Client #3 still in his bedroom. Observation on 5/13/15 at House [redacted] at 10:50 AM revealed Client #3 was in his bedroom in bed and appeared to be asleep. The observation ended at 11:10 AM with Client #3 still in bed.	W 196		

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W 196	Continued From page 36. Observation on 5/14/15 at House [redacted]1 at 2:10 PM revealed Client #3 was in his bedroom lying face down on the floor with the lights out. At 2:14 PM a staff went into the bedroom and came out a short time later and indicated that Client #3 was having an " emotional moment ". (He could be heard crying from the living room of the house.) At 2:32 PM the staff was standing in the doorway of the room, but Client #3 did not come out. At 2:35 PM a different staff was able to get Client #3 to come out of the room and go into the kitchen to get something to eat. Observation on 5/18/15 at House [redacted]1 at 3:05 PM revealed Client #3 was in his bedroom sitting on his bed doubled over with his face on the bed. At 3:15 PM a staff went into his room and asked if he wanted to come out. Client #3 declined. At 3:26 PM the staff went to check on him and at that point Client #3 left his bedroom and went into the bathroom. The observation ended at 3:28 PM with Client #3 still in the bathroom. Review of the file on 5/18/15 for Client #3 revealed his IHP dated 8/22/14 did not directly address Client #3 ' s propensity for choosing not to participate in activities such as work. Interview on 5/19/15 with the QIDP assigned to Client #3 verified that inactivity is a big issue with him and that his IHP did not directly address the root cause of refusing to participate in activities. She revealed Client #3 ' s mother has made demands related to how the facility should treat Client #3 which often led to increased lack of involvement in potential training activities.	W 196		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN	W 247		

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W 247	Continued From page 37 The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to allow four Sample Clients (#3, #6, #11, #12) to manage their own food preferences and self-manage their daily routines. These failures prevented Clients from exercising freedom of choice and self-management. Findings include: 1. Observation on 5/12/15 at lunch time, revealed Client #11 was not offered a choice of what to have for lunch. The staff assisted her to serve herself the meal which had been prepared at the facility ' s main kitchen. Observation On 5/13/15 at breakfast time, revealed Client #11 was not offered a choice of what to have to eat. The staff assisted her to serve herself the meal which had been prepared at the facility ' s main kitchen. Observation on 5/14/15 of dinner time revealed Client #11 was not offered a choice of what to have to eat. The staff assisted her to serve herself the meal which had been prepared at the facility ' s main kitchen. Observation on 5/15/15 at lunch time, revealed Client #11 was not offered a choice of what to have for lunch. The staff assisted her to serve herself the meal which had been prepared at the facility ' s main kitchen.	W 247		

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W 247	Continued From page 38 Interview on 5/14/15 with staff during the dinner meal revealed Clients are not offered choices of something else to eat unless they refuse the meal from the main kitchen. 2. Observation on 5/12/15 at 3:15 PM at House 315 revealed Client #6 was standing near the coffee maker in the kitchen. A direct care staff asked her if she wanted coffee. Client #6 said "please." Staff made instant coffee for Client #6. Client #6 did not help make the coffee. Review on 5/19/15 of the Individual Habilitation Plan (IHP) dated 11/5/2014 for Client #6 revealed under the Summary of Needs sections, Client #6 needed to make her own coffee. Observation on 5/13/15 at 8:42 AM revealed a direct care staff instructed Client #6 to get her lunch. Staff pulled out a brown lunch sack and indicated the sack was empty. The staff indicated another client likes to eat Client #6's lunch meat spread. Client #6 said "no lunch". The direct care staff put together a lunch for Client #6 using available food. Client #6 did not help put her lunch together. Client #6 said "thank you." Review on 5/19/15 of the IHP dated 11/5/2014 for Client #6 revealed Client #6 can open the refrigerator and can select preferred items. Observation on 5/13/15 at 11:25 AM revealed Client #6 was sitting at a work station at ATP. The staff instructed Client #6 to get her lunch out of the refrigerator. Client #6 did not get her lunch out of the refrigerator. Staff removed Client #6's lunch from the refrigerator, unpacked the lunch, scooped the lunch meat onto a plate, poured a	W 247		

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W 247	Continued From page 39 can of soup into a cup, heated the soup in a microwave, poured the heated soup into two small glasses and placed a clothing protector on her. Client #6 did not assist with the set up of the meal. Interview with the QIDP on 5/21/15 revealed Client #6 should be doing more for herself. 3. On 5/14/15 between 4:51 PM to 5:25 PM Client #12 was observed eating dinner in the dining room of House 301/302. Client #12 ate two dishes of food and a salad. At 5:17 PM Staff F told Client #12 that she was done with her meal. At 5:21 PM Client #12 continued to try to spoon out more food from her empty bowl. Client #12 then got up from the table and took her bowl to the serving table and sat it down in front of the serving tray. Staff H told Client #12 that she had had all the food she could have according to her diet. Staff H confirmed with another staff that Client #12 had had two servings. During an interview with Staff H at 5:34 PM he reported that he would like to give Clients more food but they have diet restrictions. Client #12 was observed to be thin in stature. A record review on 5/18/15 found a Consent for dietary restrictions for Client #12 that was not signed by her legal guardian. The guardian wrote on the consent that she believed the dietary restriction for Client #12 was on hold because Client #12 had lost weight. However Client #12's 6/12/14 IHP indicated that she was on an 1800 calorie a day diet. A 5/19/15 interview with Qualified Intellectual Disability Professional revealed that there were no longer any dietary restrictions for Client #12	W 247		

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W 247	Continued From page 40 and the consent should not have been in Client #12 ' s program record. A 5/19/15 interview with Staff H verified that there were no dietary restrictions for Client #12.	W 247		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop individualized Active Treatment Schedules for two of 13 Sample Clients (Clients #3, #11). Failure to develop Active Treatment Schedules prevented staff from knowing what to do at any given time for Clients. Findings include: Client #11 a. Review on 5/20/15 of Client #11 ' s file revealed there was no active treatment schedule. b. Interview on 5/15/15 with Staff L revealed there were no individualized Active Treatment Schedules for Clients at House 319/320 including Client #11. Interview on 5/20/15 with the Qualified Intellectual Disabilities Profession (QIDP) assigned to Client #11 verified there was no active treatment schedule for her. Client #3: a. Review on 5/18/15 of Client #3 ' s file revealed there was no active treatment schedule..	W 250		

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W 250	Continued From page 41 b. Interview on 5/19/15 with Staff M about an active treatment schedule for Client #3 revealed there were Post Schedules for staff and a generic activities schedule for the house, but no individualized active treatment schedule for Client #3.	W 250		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of 13 Sample Clients' (Client #11) Individual Habilitation Plan (IHP) was updated and revised when the Client met the training criteria for a program. This failure prevented the Client from having the opportunity to learn new skills. Findings include: Review on 5/20/15 of Client #11's file revealed her IHP dated 6/9/14 contained a training objective for participating in leisure activities. The Qualified Intellectual Disabilities Professional's (QIDP) Review listed the objective as: "[Client #11's first name] will cooperate with using leisure items offered by staff with verbal prompt on 80% of trials for 3 consecutive months". The QIDP Review indicated Client #11 had met	W 255		

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W 255	Continued From page 42 criteria for all 12 months of the year 2014. There was no review for 2015. Interview on 5/20/15 with the QIDP assigned to Client #11, with Client #11 ' s record present, verified the program had not been updated or revised when Client #11 met the criteria for the program.	W 255		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that two of 13 Sample Clients (Clients #3 and #11) had training programs that were updated and revised when they did not meet progress. This failure prevented Clients from learning the skills the facility determined were a priority for them to become more independent. Findings include: a. Review on 5/20/15 of Client #11 ' s Qualified Intellectual Disabilities Professional (QIDP) Review, last updated 5/12/15, revealed Client #11 had programs for dressing, money management, serving herself food, clearing the table, communication, and napkin use. For all 12 months of the year 2014, the QIDP assessed the programs as not meeting criteria. There was no	W 257		

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W 257	Continued From page 43 evidence the programs had been changed. Interview on 5/20/15 of the QIDP assigned to Client #11, with Client #11 ' s record present, verified no changes had been made to the programs to attempt to make progress on achieving the objective. b. Review on 5/18/15 of Client #3 ' s QIDP Review, last updated 5/6/15, revealed Client #3 had programs for toileting accidents, showering, tooth brushing, shaving, and using a vending machine. The QIDP review for the months of September, 2014 through March, 2015 revealed Client #3 did not meet criteria during any of these months on these programs. There was no evidence the program had been updated or revised. Interview on 5/19/15 with the QIDP assigned to Client #3 verified that no changes had been made on the programs when lack of progress had been identified.	W 257		
W 268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff interacted with one Sample Client (Client #4) and two Expanded Sample Clients (#29 and #24) in a manner which promoted their dignity and taught them appropriate ways of interacting with others. Staff were observed engaging in undignified	W 268		

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W 268	Continued From page 44 behavior when they allowed a client to sit on their lap, blow raspberries, pinch bottoms, twirl strings and spin staff in office chairs. Other Clients were observed carrying their own restraint devices. Failure to ensure staff interacted appropriately with Clients, resulted in one client acting in a manner which called negative attention to himself and stigmatized other Clients by having them carry their own restraint devices in public. Findings Include: Observation on 5/12/15 between 2:25 PM and 3:57 PM revealed Client #24 was sitting in a chair. A staff asked Client #24 if he wanted something to eat. Client #24 followed the staff into the kitchen. Client #24 grabbed the staff's waist. The staff asked Client #24 if he "could dance." Client #24 grabbed the staff around the neck and the staff said "space please." Client #24 then laid his head on the staff's shoulder and the staff stated, "that ' s nice". Observation on 5/13/15 at 8:56 AM revealed Client #24 was sitting on his bed yelling, and making growling like noises. At 9:11 AM, Staff A went into the bedroom and assisted Client #24 to get dressed. At 9:15 AM Client #24 stood in the hallway by his room, yelled, screamed and made growling like noises. At 9:30 AM Client #24 walked to the living area of the home holding one pant leg up with one hand, and twirling a string in the other. Staff working in the home encouraged Client #24 to dance. Staff chanted "go [name of Client #24] y", "go [name of Client #24]y". Staff A was sitting in an office chair in the middle of the living area. Client #24 sat briefly on the staff's lap. Staff A pushed him off. Client #24 hugged Staff A and twirled the chair Staff A was sitting in. Staff	W 268		

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W 268	Continued From page 45 continued to encourage Client #24 to dance and twirl the chair Staff A was sitting in. Client #24 danced around the room holding one pant leg up with one hand and a string in the other. Observation on 5/13/15 at 9:50 AM revealed Client #24 was sitting in a chair by a window twirling strings. At 10:00 AM, Client #24 got up from the chair and walked to the patio, holding one pant leg up with one hand and twirling a string in the other. His pants were observed to be on backwards. Client #24 came back into the living area of the home. At 10:10 AM Staff B was sitting on the arm of a couch, Client #24 sat on her lap. Staff B assisted him off her lap. Client #24 pinched Staff B in the breast area. Staff B stated "safe hands" to Client #24. Observation on 5/13/15 at 1:25 PM revealed Client #24 was sitting in a chair on the porch. A direct care staff approached Client #24 and said "hi". Client #24 yelled at the staff and tossed the strings at the staff. The direct care staff tossed the strings back at Client #24. Client #24 ran into the kitchen holding the strings in one hand. Client #24 pinched Staff A's bottom and kicked at Staff A. Client #24 stuck his tongue up to his nose and staff laughed. Staff A redirected Client 24 out of the kitchen. Client #24 covered his mouth with his hand and made "raspberry" like noises. Observation on 5/14/15 between 2:40 PM and 3:30 PM revealed client #24 was sitting in a chair by the window located by the side door of the house. A direct care staff said "hi" to Client #2, and asked him if he wanted to listen to music. Client #24 twirled a string he was holding. Client #24 stood up, sat down and threw the string at the staff. Staff tossed the string back to Client	W 268		

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W 268	Continued From page 46 #24. Staff working in the home continued to encourage Client #24 to get up and dance. Client #24 danced around the living area of the home holding one pant leg up with one hand and a string in the other. Client #24 pinched a staff's bottom and Client #28 stated "he is trying to get your booty." Client #28 laughed. Client #24 made raspberry noises with his lips. Client #28 stated to Client #24 "shake it like a salt shaker." Client #28 stated "look, [name of Client #24] is trying to back it up into you." A direct care staff wiggled the string in Client #24's face. Client #24 sat on the couch and put his bottom up in the air and held his legs open with his hands. 2. Observation on 5/12/15 at 11 AM revealed Client #29 was walking in an area close to his home. Client# 29 was carrying a helmet and two other objects that were rolled up. Observation on 5/15/15 at 11:30 AM revealed Client #29 walked into his home carrying a helmet. Review of Client #29's Positive Behavior Support Plan (PBSP) dated 2/24/15 staff were instructed to apply a protective helmet and arm splints if Client #29 continued to engage in self injurious behavior. Interview with the QIDP on 5/20/15 revealed Client #29 should not carry his own restraint devices. 3. Observation of Client #4 on 5/12/15 at 4:00 PM at the facility gym revealed he left the gym with a staff and Client #4 was carrying his own helmet.	W 268		

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W 268	Continued From page 47 Observation of Client #4 on 5/14/15 at 3:32 PM revealed he was carrying a helmet to the " Lawn Activities ". At 3:53 PM he left the " Lawn Activities " carrying the helmet. Review on 5/19/15 of Client #4 ' s file revealed he had a PBSP dated 8/22/14 which indicated the use of a helmet for maladaptive behaviors. There was nothing in the PBSP which indicated Client #4 should carry the helmet himself. Interview on 5/19/15 with the QIDP assigned to Client #4 verified there was nothing in Client #4 ' s plan which directed him to carry the helmet.	W 268		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record reviews and staff interviews, it was determined that the facility failed to ensure that all emergency fire drills included documentation of any difficulties observed during the drill. Because the facility did not record evacuation-related problems, it was not possible for the facility to identify where the problems occurred or what corrective actions needed to be taken to remedy the problem. Examples included: On 5/12/15 all monthly emergency fire drills conducted by the facility since the last recertification survey were examined. None of the evacuation drill documents included any	W 448		

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W 448	Continued From page 48 notation of difficulties experienced while attempting to evacuate Clients during the time each drill was conducted. Surveyor interviews on 5/12/15 with Staff X revealed the facility had a practice of not documenting any problems or difficulties experienced by staff while attempting to evacuate Clients from each house. Though the survey team requested the facility provide any documentation of evacuation problems for the past year, none was provided. Surveyor interviews with Staff X on 5/12/15 confirmed staff and Clients are expected to fully evacuate during each drill. Staff X also reported that during some of the full evacuation drills, staff did experience difficulty gaining cooperation from some Clients to follow evacuation instructions. According to Staff X, an unknown number of Clients at different times refused to evacuate during some fire evacuation drills and were permitted to remain inside the house with staff supervision. Their refusal to evacuate, however, was not recorded in the evacuation drill documentation for further follow up.	W 448		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

April 7, 2014
CERTIFIED MAIL (7008 1300 000 7188 4580)

Dr. Asha Singh, Superintendent
Fircrest School PAT A
15230 - 15th Avenue NE
Shoreline WA 98155

RE: Recertification Survey
3/10/2014 through 3/14/2014

Dear Dr. Singh:

From 3/10/2014 through 3/14/2014 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G053	A. BUILDING _____ B. WING _____	03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Fircrest School PAT A from 03/10/14 through 03/14/14. A sample of 13 residents was selected from a census of 128. The expanded sample included 21 current residents. The survey was conducted by Penelope Rarick, B.A. Janette Buchanan, R.N., B.S. Claudia Baetge, M.A. Christina Borchardt, R.N., B.S. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Services Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2405 Fax: (360) 725-2642	W 000	RECEIVED MAY 20 2014 DSHS-ADSA Residential Care Services ICF/MR Program	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have a policy that provided operational direction related to the alteration of medications. This failure placed 5 of 21 expanded sample residents at risk of harm in	W 104	Resident # 15, 16, 17, 18, and 34's medication orders have been assessed by the medical providers and the clarified order given to the nurse. The Nursing supervisor (RN4) will review medication administration of all clients in PAT A and make sure clients receive the medication according to the order of the medical provider. Nursing Procedure I-F.6a will be	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Asha Singh — TITLE: SUPERINTENDENT — (X6) DATE: 5/16/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 receiving medications which could result in potential adverse drug reactions. Findings include: All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Review of facility policy titled Preparation and Administration of Oral and/or Enteral Medications; Nursing Procedure I-F.6a revealed the following: • N - Do not crush enteric-coated or time-release tablets or capsules. Contact the Pharmacist or Physician if such medications are ordered; to facilitate change to more appropriate medication/dosage. Nursing Procedure I-F.6a specified what medication should not be crushed. However, the Nursing Procedure was limited in that it did not provide operational directions on the Physician's Orders to reflect which medications were approved to be crushed. Observation of medication administration revealed nurses administering medication in accordance with Physician orders as follows: • Resident #15 received Calcium 600/400 Vit. D crushed in applesauce at 3:30 pm 03/10/14. • Resident #16 received Calcium 600/400 Vit. D crushed in pudding at 3:30 pm 03/10/14. • Resident #17 received [redacted] 500 mg crushed in pudding at 3:30 pm 03/10/14. • Resident #18 received [redacted] 50mg and [redacted] 25 mg crushed in juice with [redacted] 10 ml at 7:30 am 03/11/14. • Resident #34 received [redacted] .05mg. tablet, Multivitamin-Mineral tablet and [redacted] 8.6 mg tablets on 03-10-14 at 8:00 am crushed in pudding. Review of Physician orders for Resident #15, 16, 17, 18 and 34 revealed no orders to crush	W 104	modified to indicate that medication should not be crushed unless it is specified by the provider. All PAT A nurses will be in-serviced that nurses will not crush medication without the provider order. All information that indicates clients preference to crush medications will be removed from the Medication Administration Record (MAR). Crushing medication for clinical purposes will have a physician order and will be indicated on the MAR. These action plans will be monitored quarterly through the medication observation sheet by lead LPN's (LPN4) and will be monitored and filed by RN4 Completion Date: 5/14/14 Person Responsible: RN 4	

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5/16/14

DEPARTMENT OF HEALTH AND HUM. SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 104	Continued From page 2 medications that were administered during observation. Review of medication bubble packs (bingo cards) or over the counter bottles of medications did not have directions from the Pharmacy or Physician that instructed Nursing staff whether a medication could or could not be crushed. Review of the residents ' Medication Administration Record (MAR) revealed a document titled Medication Book Information, which included " Medication Administration Preference. " Nursing staff dispensing medications to the residents followed the " Medication Administration Preference " section on the Medication Book Information sheet which stated for example: " Takes meds crushed with pudding. " Interview with Staff Y on 03/31/14 revealed all medication orders are to be given as ordered unless otherwise specified. Staff Y stated she would be concerned medications were being crushed which should not be and could alter the therapeutic value. She stated the original medication orders came from the Physician. When orders get to the Pharmacy, the Pharmacist alerts staff to whether there were any specialized instructions such as, whether a medication could or could not be crushed, whether a medication needs to be given prior to a meal or not; whether a medication should be given with other medications, or whether a medication should be given in the morning or evening. Interview with Staff C on 03/13/14 revealed " Medication Administration Preference " may have come from preference input from the resident/family or the dietary department. Staff C acknowledged that it was unclear as to where the document originated.	W 104		

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W 109	483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to comply with State Regulation (WAC 246-215-04710) ensuring all equipment, food contact surfaces and utensils were sanitized. This failure placed residents at risk for illness due to exposure by cross contamination. Findings include: All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified. Interview with Staff S indicated the main kitchen dishwasher temperature is checked daily to ensure the correct temperature is reached for the sanitization process. Kitchen staff place a Thermolabel (temperature sensitive tape) on an item that goes through the dishwasher-ensuring hot water sanitation. At the end of the dishwashing cycle, the Thermolabel is placed on the Dishwashing Machine Temperature Chart. Record review of the Dishwashing Machine Temperature Chart for March 2014 revealed after the dishwasher temperatures were checked, Thermolabels were placed on the chart in an	W 109	The chart for the retention of the Thermolabel was revised so that there would be no overlapping labels. All staff were again trained on the requirements for the wash, rinse and sanitizing process when the dishwasher is not available for use. Signs with the correct process were posted at the sinks for easy reference. The dishwasher / sanitizer was fixed during the time of the survey. This issue was added to the supervisor's checklist as a monitoring tool. They are to look at the chart with the Thermolabels to assure that the correct process is being followed. If the dishes are being washed by hand, the supervisor is to monitor the process to assure that the correct mix of sanitizing solution is used for washing. Completion Date 3/14/14 Person Responsible: Food Services Manager	

Abrugh 5/16/14

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W 109	Continued From page 4 overlapping manner making it difficult to determine which days the dishwasher temperatures were checked. There were no readings on March 1st and 2nd and only two days in which readings displayed the desired temperature of 160°. Staff S acknowledged she had not been notified of problems with the dishwasher and she was unable to determine how long there had been problems with the temperature sanitation cycle. Interview with Staff S revealed when the main kitchen dishwasher was not available for use, staff would use the three compartment sink to wash, rinse and sanitize tableware, utensils and equipment. Observation of wash, rinse and sanitize process revealed staff did not understand how to sanitize tableware, utensils and equipment correctly or how long to sanitize items. When interviewed how long items were sanitized: Staff S responded 1 minute, Staff T indicated 20 seconds and Staff U was not sure.	W 109		
W 116	483.410(c)(6) CLIENT RECORDS The facility must provide each identified residential living unit with appropriate aspects of each client's record. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff had access to the most current and relevant information for 6 of 13 sampled residents (Resident #4, 8, 10, 11, 12, & 13) available in resident program books, dining books and/or main chart. This failure placed residents at risk of receiving inappropriate care due to staff not	W 116	A work group developed a standardized process for content within client program books that will be used in the Program Area Team (PAT). Program books will be assigned per client staffing post. Each interdisciplinary team will review the program book annually and when programs change to ensure that each book contains the most recent version of the Implementation Plans for each client.	

Asmyth 5/16/14

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 116	Continued From page 5 knowing residents ' current functioning level, medical issues, dietary issues and restrictive practices. Findings include: All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified. Program books with missing Positive Behavioral Support Plans (PBSP): Resident #8, Resident #10, Resident #12 and Resident #13. Program books with outdated PBSP ' s: Resident #11. Program books with outdated PBSP Directions for Staff: Resident #4. Observation of units revealed each unit had a different approach for what resident information was available for staff and how information is provided for staff. Some units provided one program book per resident which may include training/behavioral/medical information. Other units had combined resident program books and/or several program books per resident. Interview with Staff I and J revealed based on information being out of date in program books, unit staff refer to the resident ' s main red book when training new staff. Interview with Staff L, M and N revealed Program Books are used by staff to help understand the needs of residents. Interview with Staff Q revealed floating staff, unfamiliar with the unit, have expressed difficulty finding relevant resident information due to inconsistencies regarding the types and quantities of resident program books on each unit. Interview with Staff B acknowledged program books must include the most updated and	W 116	Dining books will be reviewed by the Attendant Counselor Managers to ensure that the most recent version of the Nutritional Management Plan and Dining Guidelines are in place. Dietary staff will review dining books monthly to ensure that the most recent Diet Orders are within the Dining Book and the chart. The QI Department will monitor one program and one dining book per house (picked randomly) one time monthly to assure that the information contained in the books is current. The results of these random checks will be given to the PAT A Director and DDA1 for followup as needed. Target Completion Date: 5/14/14 Person Responsible: DDA 1; PAT A Director	

Approved
5/16/14

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W 116	Continued From page 6 relevant resident information however Staff B agreed the facility does not have uniformed approach for how or what type of resident information is offered in program books. Observation of resident meal books/main chart revealed the following: Resident #5: Review of dining book and resident main chart revealed Dining Guidelines Latest Updates-Diet Orders: 10/10/11 and Nutritional Management Plan (NMP): 09/14/2012. Staff W provided an updated Dining Guidelines for Resident #5 which revealed updated information to include Diet Orders: 1/23/14 and NMP: 09/13/13. The updated Dining Guidelines, document was not found in the resident dining book or main chart.	W 116		
/ 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff followed directions with regards to the Vagus Nerve Stimulator (VNS) magnet for 1 of 13 sampled residents (Resident #6). This failure placed resident at risk of medical complications from an unmanaged seizure. Findings include: All observations, record reviews and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.	W 192	Written expectations have been given to the Attendant Counselors (AC) staff on 311/312 regarding the use of the Vagal Nerve Stimulator (VNS) for resident #6. A form was developed for the staff on any unit with a client who has a VNS to document the exchange of the VNS between the shifts to ensure its location. All AC staff who support clients who have VNS magnets will be re-trained on the VNS guidelines that the expectation that the VNS magnet is on their person at all times.	

5/16/14

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W 192	Continued From page 7 Review of Resident #6 ' s Annual Medical Review (06/12/13) revealed Resident #6 was diagnosed with a seizure disorder and had a Vagus Nerve Stimulator (VNS) implanted to assist in the management of his seizure activity. VNS is used to prevent seizures by sending regular, mild pulses of electrical energy to the brain via the Vagus nerve. If the regular interval electrical pulses do not prevent a seizure, a magnetic wand can be used to deliver an extra pulse of stimulation. This extra electrical stimulation can stop the seizure, shorten the seizure, or reduce the seizure severity. Review of nursing directions to staff (11/07/13) revealed staff should keep the magnet (VNS) on their person at all times and away from credit cards and watches. If staff notice any symptoms of seizure activity they are to immediately use the magnet by passing magnet over the area from his left armpit to his left nipple 1-2 times, if seizure does not stop, repeat after 5 seconds and keep repeating. Observation of Unit 312 at 4:00pm on 03/12/14 revealed VNS magnet wrapped around staff walkie talkie radio and left on chair outside of Resident #6 ' s bedroom. Staff X was providing 1:1 supervision with Resident #6 in living room area for approximately 15 minutes. Interview with Staff X revealed she failed to have VNS in her possession while supervising Resident #6 in the living room. Staff X stated the unit had two extra VNS magnets both located behind locked cabinets in the living area. However Staff X acknowledged due to her failing to have VNS in her possession she would have been unable to provide immediate medical intervention if a seizure were to occur.	W 192	A question was added to the PAT A Observation form checking whether a staff who is assigned to a client who uses a VNS has it on their person. Appropriate action will be taken if the staff does not have the VNS on their person. The PAT Observation forms are given to the PAT A Director for over-sight. Target Completion Date: 5/14/14 Person Responsible: Acting PAT A Director; RN4	
W 262	483.440(f)(3)(i) PROGRAM MONITORING &	W 262		

5/16/14

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W 262	Continued From page 8 CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure Human Rights Committee (HRC) had reviewed and/or approved restrictive procedures for 2 of 13 sampled residents (Resident #10 & 13), 2 of 21 expanded sampled residents (Resident #14 and 34) and 5 of 18 Units (Unit 308, 315/316 and 319/ 320). This failure placed residents at risk of harm due to facility using restrictive procedures that were not approved by the HRC. Findings include: All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Resident #10: Record review revealed Resident #10 ' s HRC Restrictive Procedures Review Tracking Form for residents Positive Behavior Support Plan (PBSP) had not been reviewed or updated by HRC since 08/09/12. Review #13: Observation revealed Resident #13 had a pommel positioning device placed on a wheelchair between resident ' s legs in order to prevent resident from sliding forward. This restrictive device must be removed by staff in	W 262	Resident #10's Positive Behavior Support Plan (PBSP) has been reviewed by the Human Rights Committee (4/10/14). A consent for use of the abductor support on the wheel chair of resident #13 was obtained by telephone on 3/15/14. The restrictive process will be reviewed by the Human Rights Committee and a written consent approval will be sought by the guardian in May. Resident #14's clothing is no longer locked up in the supply room and she has access to it. Resident #34 was incorrectly identified and should now be resident #35. The cabinet has been unlocked and a work order placed to have the hasp taken off the cabinet so it can't be locked in the future. The cabinet containing hygiene/ grooming kits and razors on house 308 is no longer locked. The cabinet on 315/316 containing Depends undergarments, wipes and toilet paper is no longer locked. Consents for locking the exterior gates around 319/320 have been sent out to guardians. As the consents come back signed, the restrictive procedure is	

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5/16/14

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W 262	Continued From page 9 order for resident to enter and exit the wheelchair. Review of Resident #13 ' s record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Resident #14: Observation revealed Resident #14 had two boxes of clothes stored in the unit ' s locked supply room. Resident #14 was aware of the additional clothes in the locked room but must ask for staff assistance to access the locked room. Review of Resident #14 ' s record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Resident #34: Observation revealed a locked cabinet in the dining room which contained snack items for Resident #34. Review of Resident #34 ' s record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Unit 308: Observation revealed a locked cabinet which secured hygiene/grooming kits and razors for residents. Interview of Staff K revealed items had been locked due to a safety concern regarding a unit resident who ingests dangerous substances to include liquid items such as shampoos and/or metal and plastic items. Staff K acknowledged HRC had not reviewed and/or approved the restrictive procedure before it was implemented. Unit 315/316: Observation of Unit 315/316 revealed locked cabinets in the bathrooms which contained Depends undergarments, wipes and toilet paper.	W 262	being reviewed by the Human Rights Committee. A training on restrictive processes or actions will be held for all interdisciplinary team members in PAT A so that future restrictions on PAT A clients will receive approval from guardians and the Human Rights Committee prior to initiation of the restrictive process or action. Target Completion Date: 5/14/14 Person Responsible: PAT A Director, DDA 1 and Lead Psychologist	

5/8/14

DEPARTMENT OF HEALTH AND HUM. SERVICES
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W 262	Continued From page 10 Review of Unit 315/316 resident records revealed HRC had not reviewed and/or approved the restrictive procedure before they were implemented. Unit 319/320: Observation of Unit 319/320 revealed there were four exterior gates (3 in the back of the unit and 1 off the patio in the front) which restricted 16 residents from entering and exiting the unit without the assistance of the staff. Interview with Staff D acknowledged the gates were locked due to the concerns regarding potential elopement of two residents. Review of records that reside on Unit 319/320 revealed that two residents out 16 residents on the unit were at risk of elopement HRC had not reviewed and/or approved the restrictive procedure before it was implemented.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure residents' guardians reviewed and/or approved restrictive procedures for 1 of 13 sampled residents (Resident #13), 2 of 21 expanded sample residents (Resident #14 and 34) and 5 of 18 Units (Unit 308, 315/316 and 319/320). This failure denied the residents/guardians the opportunity to make informed decisions about facility restrictive practices and denied residents	W 263	The Human Rights Committee was unable to review the restrictions identified as they were not presented with the process for review. A training on restrictive processes or actions will be held for all interdisciplinary team members in PAT A so that future restrictions on PAT A clients will receive approval from guardians and the Human Rights Committee prior to initiation of the restrictive process or action. Resident #10's Positive Behavior Support Plan (PBSP) has been reviewed by the Human Rights committee (4/10/14).	

Approved
5/16/14

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W 263	Continued From page 11 their right of free access to their property. Findings include: All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified. Resident #13: Observation revealed Resident #13 had a pommel positioning device placed on a wheelchair between resident ' s legs in order to prevent resident from sliding forward. This restrictive device must be removed by staff in order for resident to enter or exit the wheelchair. Review of Resident #13 ' s record revealed no documentation to indicate guardians had reviewed and/or approved the restrictive procedure before it was implemented. Resident #14: Observation revealed Resident #14 had two boxes of clothes stored in the unit ' s locked supply room. Resident #14 was aware of the additional clothes in the locked room but must ask for staff assistance to access the locked room. Review of Resident #14 ' s record revealed there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Resident #34: Observation revealed a locked cabinet in the dining room which contained snack items for Resident #34. Interview with Staff P acknowledged cabinet should not have been locked and there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Unit 308: Observation of Unit 308 revealed a locked	W 263	A consent for use of the abductor support on the wheel chair of resident #13 was obtained by telephone on 3/15/14. The restrictive process will be reviewed by the Human Rights Committee and a written consent approval will be sought by the guardian in May. Resident #14's clothing is no longer locked up in the supply room and she has access to it. Resident #34 was incorrectly identified and should now be resident #35. The cabinet has been unlocked and a work order placed to have the hasp taken off the cabinet so it can't be locked in the future. The cabinet containing hygiene/ grooming kits and razors on house 308 is no longer locked. The cabinet on 315/316 containing Depends undergarments, wipes and toilet paper is no longer locked. Consents for locking the exterior gates around 319/320 have been sent out to guardians. As the consents come back signed, the restrictive procedure is being reviewed by the Human Rights Committee. Person Responsible: PAT A Director, DDA 1 and Lead Psychologist Target Completion Date: 5/14/14	

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W 263	Continued From page 12 cabinet which secured hygiene /grooming kits and razors for residents. Interview of Staff K revealed items had been locked due to a safety concern regarding a unit resident who ingests dangerous substances which include liquid items such as shampoos and/or metal and plastic items. Staff K acknowledged there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Unit 315/316: Observation of Unit 315/316 revealed locked cabinets in the bathroom which contained Depend under garments, wipes and toilet paper. Interview with Staff N revealed bathroom cabinets were routinely locked up. Record review revealed there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Unit 319/320: Observation of Unit 319/320 revealed there were four exterior gates (3 in the back of the unit and 1 off the patio in the front) which restricted 16 residents from entering and exiting the unit without the assistance of the staff. Interview with Staff D acknowledged the gates were locked due to the concerns regarding potential elopement of two residents. Review of records that reside on Unit 319/320 revealed that two residents out 16 residents on the unit were at risk of elopement which guardians had not reviewed and/or approved the restrictive procedure before it was implemented.	W 263		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.	W 323	Residents #6, #9, #10, #12 and #13 have had vision exams scheduled.	

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5/16/14

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W 323	Continued From page 13 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 5 of 13 sampled residents (Resident #6, #9, #10, #12, & #13) received annual and/or as recommended vision exams. Failure to provide a timely vision exam placed residents at risk of unidentified changes in vision and other medical issues which could lead to deterioration in their overall health. Findings include: All record reviews and interviews were completed between 03/10/14 and 03/14/14, unless otherwise specified. Resident #6: Review of medical chart revealed resident had not had a vision exam since being admitted to facility on 10/31/2011. Resident #9: Review of Ophthalmology Consultation dated 09/07/12 revealed resident had developing cataracts which were gradually worsening. Assessment recommendations included holding off on surgery and to recheck in another year. Interview with Staff O acknowledged that Resident #9 had not been rechecked since exam dated 09/07/12. Resident #10: Record review revealed that the last vision exam was 07/07/08 with a recommendation for resident to have his eye sight followed on a routine basis. There was no documentation provided to indicate a follow up exam had occurred. Resident #12: Review of medical chart revealed resident had not had a vision exam since being admitted to facility on [redacted]11.	W 323	A review of all other PAT A clients will occur to assure that all clients have had a vision exam based upon their particular clinical needs, or an initial exam as a baseline. Admission History and Physical and Annual Medical Evaluations include evaluation of the client's eyes, as well as review of health history, including ophthalmologic. The health care provider will request ophthalmologic consultation for any concerns. At each Individual Habilitation Plan (IHP) meeting, the Health Care Coordinator (RN) will review the chart to ensure consultations are completed and treatment plans implemented. Target Completion Date: 5/14/14 Person Responsible: RN 3	

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W 323	Continued From page 14 Resident #13: Record review revealed last vision exam had been 01/20/00 with recommendations to have a routine follow up vision exams. There was no documentation provided to indicate a follow up exam had occurred.	W 323		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a pharmacist provided thorough reviews of drug regimens for 13 of 13 sampled residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) during the quarterly review process. This failure placed residents at risk of inappropriate medication management and risk for potential medication errors. Findings include: All record reviews and interviews were completed on 03/10/14 through 03/26/14 unless otherwise specified. Review of Pharmacy Notes revealed each pharmacist had a different approach regarding how drug regimens were reviewed for each resident. Pharmacy Notes failed to include a review of all drugs in residents ' drug regimen, failed to consistently indicate which drugs were reviewed, failed to consistently describe the	W 362	A separate tab labeled "Pharmacy" will be added to each client's chart. This section will contain the following standardized information for each 90 day pharmacy review: • Client name, home, ID#, date of birth • Immunizations • Acute Medical Problems in the past 90 days • Current medication list with dosage and frequency information • Diagnoses with recent laboratory results, any appointments, consultations, medication usage and response during this period • Laboratory results and schedule for routine screening • Recommendations by Clinical Pharmacist with outcomes • Clinical Pharmacist's signature and date	

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W 362	Continued From page 15 residents ' response to the drug regimen and failed to be signed by the pharmacist. Review of Pharmacy Notes revealed no evidence to support a complete review of drug regimen or response to the drug regimen for the following residents: Resident #1 Review of Resident #1 Medication Administration Record (MAR) dated 2/21/14 revealed a medication regimen to include: [redacted] Multivitamins-Minerals, [redacted] and [redacted] Pharmacy Notes dated 3/5/14 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug. Resident #2 Review of Resident #2 MAR dated 12/23/13 revealed a drug regimen to include: Acetaminophen, Baby oil, Coal Tar, [redacted] and [redacted] Pharmacy Notes dated 1/7/14 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug. Resident #3 Review of Resident #3 ' s MAR dated 12/23/13 revealed a drug regimen to include: [redacted] Pharmacy Notes dated 12/23/13 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug.	W 362	The Pharmacy Supervisor will conduct random chart reviews of each Clinical Pharmacist's assigned areas to ensure that the consistent and standardized input of the clinical pharmacist is clearly reflected in the record of each client. COMPLETION DATE: 5/09/14 PERSON(S) RESPONSIBLE: Lead Pharmacist Pharmacy Supervisor	

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W 362	Continued From page 16 Resident #4 Review of Resident #4 Medication Profile revealed a drug regimen to include: [redacted] Pharmacy Notes dated 1/7/14 did not include a list of reviewed drugs or information regarding the residents ' response to the drug. Resident #5 Review of Resident #5 Medication Profile revealed a drug regimen to include: Aspirin, [redacted] Pharmacy Notes dated 1/22/14 did not include a list of reviewed drugs or information regarding the residents ' response to the drugs. Resident #6 Review of Resident #6 Medication Profile revealed drug regimen to include: [redacted] Vitamin C, Vitamin E, Vitamin B2, and [redacted] Pharmacy Notes dated 1/29/14 did not include a list of reviewed drugs or information regarding the residents ' response to the drug. Resident #7 Review of Resident #7 Medication Profile revealed a drug regimen to include: [redacted] Pharmacy	W 362		

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W 362	Continued From page 17 Note dated 02/04/2014 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #8 Review of Resident #8 Medication Profile revealed a drug regimen to include: Calcium Carb/Vitamin D, 3 Multivitamin, 3 Oint for eyes. Pharmacy Note dated 03/11/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #9 Review of Resident #9 Medication Profile Review revealed a drug regimen to include: 3 Multivitamins-Minerals, 3 Powder, Calcuim Carb/Vit D and 3 ear drops. Pharmacy Note dated 03/11/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #10 Review of Resident #10's Patient Medication Profile revealed a drug regimen which included 3 1% Powder. Pharmacy Notes dated 02/11/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #11 Review of Resident #11's Patient Medication	W 362		

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W 362	Continued From page 18 Profile revealed a drug regimen which included Vitamin D and [redacted] Pharmacy Notes dated 02/11/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #12 Review of Resident 12's Patient Medication Profile revealed a drug regimen which included [redacted] Multivitamin with minerals, [redacted] suppository, [redacted] daily cleanser, and Hoy cream. Pharmacy Notes dated 01/15/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Resident #13 Review of Resident #13's Patient Medication Profile revealed a drug regimen which include [redacted] (Generic) Coal Tar 3% Shampoo, [redacted] Shampoo, Sodium, [redacted] Moisturizing Cream (for [redacted] Multivitamins-Minerals, [redacted] 0 mg Supp. Pharmacy Notes dated 01/15/14 did not include a list of reviewed drugs or information regarding the resident's response to the drug. Interview with Pharmacy team revealed the Pharmacy Notes are completed during the 90 Day Interdisciplinary Team (IDT) meeting. Pharmacists revealed the IDT meeting didn't always provide enough time to document a complete drug review. The pharmacists	W 362		

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W 362	Continued From page 19 acknowledged inconsistencies with the type of information provided in the Pharmacy Notes. The Pharmacy team acknowledged they do not provide a copy of the Pharmacy Notes for the residents ' chart as required per policy (Procedure for Medication Regimen Review #p:1.2 revised 08/2013) nor sign the Pharmacy Notes.	W 362		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to keep medication carts locked during medication administration for 2 of 18 units (Unit 309 (317) & 315). This failure placed residents at risk of harm due to accessibility of unsecured drugs. Findings include: All observations and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Observation on 03/10/14 on Unit 315 revealed Staff V had placed the medication cart in the center of living room. Staff was observed quickly returning to the unlocked medication cart after dispensing medication to a resident approximately 20 feet from the cart. Interview with Staff V acknowledged this was acceptable per policy, as long as she could see	W 382	Staff V and all other nursing staff will be in-serviced that medication carts need to be secured and in front of the nursing staff at all times. Even if the cart is within a line of sight, if the nurse steps away from the cart the cart needs to be locked at all times. If the resident cannot come up to the cart to take their medication, the nurses need to take the medication cart and the Medication Administration record with them to the client location and administer the medication. The Nursing supervisor (RN4) observed the medication administration by nurses of all clients in PAT A to assure the med cart was secured and locked according to the procedure and nursing practice. Medication cart security procedure will be added on the Nursing procedure I-F.6a	

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W 382	Continued From page 20 the medication cart: Observation on 03/11/14 on Unit 309 (317) revealed the medication nurse brought the medication cart into living room area and parked medication cart on far side of living room. Staff walked over to the sink on opposite side of the room to fill her water container and left cart unlocked and within reach of a resident. Interview with Staff C revealed nursing practice dictates medication carts should be in front of the nurses at all times and if resident does not come up to the cart the nurse is to lock the cart and take the medication to the resident or bring the cart to the resident in order to administer medication.	W 382	The HCC (RN2) and the LPN 4 will observe medication administration of all clients in PAT A quarterly and sporadically and do spot checks to make sure nurses follow Nursing Procedure I-F.6a and report to RN4. Target Completion Date: 5/14/14 Person Responsible: RN 4	
W 424	483.470(d)(1) CLIENT BATHROOMS The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed ensure 2 of 2 bathrooms had mirrors by the sink/tooth brushing area for 1 of 13 sampled residents (Resident #5) and 6 of 21 expanded sampled residents (Resident #19, #20, #21 #22, #23 and #24). This failure prevented residents from maintaining good hygiene and violated residents' right to independence, personal choice and dignity. Findings include: All observations, record reviews and interviews occurred between 03/09/14 and 03/14/14 unless otherwise specified.	W 424	Non-breakable plastic mirrors were installed in the bathrooms and secured to the wall on house [redacted]. The issue of bathrooms having all necessary components (mirrors, toilet paper, etc.) will be included in a new QI Rights/Restrictions checklist. This checklist will be completed by QI staff and the results of these observations given to the PAT A Director for appropriate followup. Target Completion Date: 5/14/14 Person Responsible: PAT A Director QI Director	

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W 424	Continued From page 21 Observation of unit [redacted] revealed both resident bathrooms failed to have mirrors. Interview of staff revealed Resident #20 had ingested some glass after breaking a picture frame. In response to safety concerns for Resident #20, all glass items were immediately removed from area, including the bathroom mirrors. Interview of Staff G acknowledged there had been discussion regarding bathroom mirror replacement and the best way to offer a reflective mirror type device that would not place Resident #20 at risk if he were to break or ingest the frame or glass. Staff G revealed they had not yet determined how or when the bathroom mirrors would be replaced. Review of facility Incident Report (02/08/14) revealed bathroom mirrors were removed on 02/08/14. The facility failed to provide bathroom mirrors for five weeks..	W 424		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure evacuation drill times and evacuation routes varied during evacuation drills for all units. This failure placed residents at risk of harm should an emergency occur that necessitates evacuation. Findings include:	W 441	Fire evacuation drills will be conducted at varied times. Some drills will be conducted on the weekends to include clients who may be at school or week during the work week to accommodate this requirement. Evacuation routes will be varied by indicating to staff the location of the practice fire and changing the location of the practice fire each drill.	

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W 441	Continued From page 22 All record reviews and interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified. Review of facility 2013 Fire Drill Schedule revealed quarterly drill times for 2nd shift were performed within the same two hour time frame on units 301/302, 303/304, 305/306, 307/308, 311/312, 313/314, 315/316, 317/318, and 319/320. Quarterly drill times for 3nd shift were performed within the same two hour time frame on 301/302, 303/304, 305/306, 311/312, 313/314, 315/316 and 317/318. Interview of Staff K revealed daytime shift fire drills were planned around resident Active Treatment Program schedules and staff availability. Staff K acknowledged drill times were not varied to include different times of the day and for the 2nd and 3rd shift. Review of All-Hazards operations Plan Drill Forms for 2013 revealed houses 303/304, 305/306, 307/308, and 309/310 (317/318) all practiced full evacuations out the patio door and had no variation with evacuation routes. Interview of Staff K revealed each house has 7 potential exits. During fire drills Staff K provides a mock fire situation for each house and acknowledged that based on these mock situations the houses would naturally exit out the back patio. Staff K acknowledged the mock situations did not allow a practice opportunity for staff and residents to vary the evacuation routes.	W 441	The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that all requirements of the drill have been met. The Safety Officer will teach the staff initiating the drill about the various requirements of the drill if it is not initiated by the Safety Officer. Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement	
W 445	483.470(i)(2)(i) EVACUATION DRILLS The facility must actually evacuate clients during at least one drill each year on each shift.	W 445	A full evacuation drill will be scheduled to be conducted on the night (NOC) shift during the warmer weather of the summer months so as to not put clients	

Through 5/16/14

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W 445	Continued From page 23 This STANDARD is not met as evidenced by: Based on interviews the facility failed to evacuate residents during at least one drill each year on each shift (3rd shift -overnight) during 2013. This failure placed residents at risk of harm from potential entrapment if an emergency should occur that necessitates evacuation during the 3rd shift. Findings include: All interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified. Interview of Staff K revealed there had been no actual evacuation drills done during the 3rd shift (overnight) for any of the units during the past 12 months.	W 445	at risk of exposure to the cold and rain. A plan for neighboring houses and the duty office to assist the home that is conducting the drill will be implemented for supervision of the clients once they have been physically evacuated. The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that an evacuation drill occurs on night shift during the calendar year. Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement	
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to file an accurate report and evaluation of each evacuation fire drill. This failure placed residents at risk of harm from potential entrapment if an emergency should occur that necessitates evacuation and caused facility to be unaware of problems which might arise during a fire drill.	W 447	The Fire Drill form has been revised to allow for indicating whether there was a full evacuation, a partial evacuation or no evacuation. The person conducting the drill and completing the form will indicate reason for not evacuating. A comment section will also be added so that additional information may be added to the form. A situation will be developed for each drill and which exits are used. Exits will be varied throughout the year to meet this requirement.	

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W 447	Continued From page 24 Findings include: All record reviews and interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified. Record Review revealed each of the 18 units (9 houses) had four quarterly fire drills during 2013. Interview of Staff K revealed at the time of each drill a designated staff-typically the safety officer (Staff K) or designated Duty Officer (3rd shift) observes the drill, completes an All-Hazards Operations Plan Drill form and identifies any problems or corrective actions based on the outcome of the drill. Review of the All-Hazards Operations Plan Drill form revealed the form was incorrectly completed by staff and staff failed to include accurate information which would allow the opportunity to identify problems. Examples included as follows: Drill Evacuations: The form included a section showing " exit used " in regards to the drill evacuation exit. The section had been completed by staff however staff did not distinguish between a mock evacuation and actual evacuation, e.g., All-Hazards Operations Plan Drill form dated 9/18/13 NOC shift Unit 301/302 revealed evacuation exit used was back patio. Interview of Staff K revealed this evacuation was a mock evacuation, not an actual evacuation, even though it was documented that the back patio was used as an exit. Staff K acknowledged when	W 447	Actual time taken to evacuate will be provided during the full evacuation drill. No time to evacuate will be documented at other fire drills. Comments from staff related to the Fire Drill will be recorded on the Fire Drill form. Any issues identified will be resolved in a timely manner. The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that all requirements of the drill have been met. The Safety Officer will teach the staff initiating the drill about the various requirements of the documentation of the drill if it is not initiated by the Safety Officer. Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement	

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W 447	Continued From page 25 reviewing the form it would be difficult for anyone but him to know if the evacuation drill was a mock versus an actual evacuation. Time to Evacuate: Review of documentation revealed all evacuations ranged between one and three minutes, e.g., All-Hazards Operations Plan Drill form dated 3/20/13 NOC shift Unit 303/304 revealed time to evacuate 16 clients with 3 staff at 04:06AM was 1 minute. However interview of Staff K revealed this drill was a mock evacuation, not an actual evacuation, so the time listed was based on how long staff believed it would take to evacuate residents rather than an accurate evacuation time. Incomplete information: Review of documentation revealed during the course of the year, several sections of the All-Hazards Operations Plan Drill form had been left blank. This included fire drill time, name of the person completing the form, problems encountered, and inspection of portable fire extinguishers. Staff K acknowledged at times he failed to review the form to ensure its completion. He also acknowledged as part of his job he should review and sign all forms which had been completed by another staff and agreed he had not consistently done this. Based on the inaccuracies and incompleteness of documentation on the All-Hazards Operations Plan Drill form one would be unable to accurately evaluate and determine if any problems occurred during a drill/evacuation.	W 447		
W 454	483.470(l)(1) INFECTION CONTROL	W 454	The plastic scoop that was used for	

Hough
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W 454	Continued From page 26 The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide a sanitary environment that was free from items and areas contaminated with urine for 1 of 13 sampled residents (Resident #5) and 6 of 21 expanded sampled residents (Resident #19, #20, #21 #22, #23 and #24). This failure placed residents at risk of being exposed to unsanitary conditions which could cause health risks. Findings include: All observations and interviews occurred between 03/09/14 and 03/14/14 unless otherwise specified. Observation of resident bathroom in Unit [redacted] revealed two plastic scoop-like items placed on bottom panel of the cabinet, underneath bathroom sink. Interview of staff revealed the plastic items were used as a urine shield when Resident #19 was on the toilet. Staff explained Resident #19 had a medical condition which caused him to inadvertently spray urine when seated on the toilet. Resident #19 will place the plastic shield over his penis when sitting on toilet in order to divert the urine back into the toilet. Interview of staff revealed after use, Resident #19 would rinse the plastic shield in the bathroom sink and place the plastic shield under sink on bottom panel of the cabinet. Staff revealed there is no system in place requiring Resident #19, or staff,	W 454	resident #19 was eliminated as he was able to be taught to use the toilet appropriately without the scoop. A question about correct sanitization processes will be added to the new QI Rights/Restrictions checklist. This checklist will be completed by QI staff and the results of these observations given to the PAT A Director for appropriate followup. Target Completion Date: 5/14/14 Person Responsible: PAT A Director QI Director	

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W 454	Continued From page 27 to sanitize the plastic shield, sink and countertop and bathroom cupboard after use of the plastic shield.	W 454		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to observe infection control practices when storing and charging electric razors for residents in 1 of 18 units (Unit 308). This failure placed residents at risk for illness from cross contamination. Findings include: All observations and interviews occurred between 03/09/14 and 03/14/14 unless otherwise specified. Observation of Unit 308 on 03/09/14 revealed six resident razors co-mingling in a small plastic container in dayroom cabinet. Observation of Unit 308 on 03/11/14 revealed five residents' razors being recharged and co-mingling in a small plastic container in cabinet of television stand located in the day room. Interview of staff revealed razors are should be stored in residents' individual hygiene containers, however when being charged they are	W 455	The Attendant Counselor Manager has given written expectations for the correct storage of client razors. The razors for clients living on 307/308 are now stored in the client's bedrooms. Proper storage of client razors will be added to the Unit Check lists to ensure that razors are not stored together. The checklists will be monitored by the Attendant Counselor Manager. In addition, a member of the QI staff will check on proper storage of razors in addition to other practices that may be interpreted as an infection control issue as part of a random check on PAT A houses. The QI checklist will be given to the PAT A Director for followup when issues have been found. Target Completion Date: 5/14/14 Person Responsible: AC Manager for house 307/308 PAT A Director Director of Quality Improvement	

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W 455	Continued From page 28 co-mingled in the plastic container.	W 455		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow dining guidelines for 2 of 13 sampled residents (Resident #4 and 7) and 2 of 21 expanded sampled residents (Resident #25 & 26). This failure caused residents to be served food that was not suitable size or texture for their eating and swallowing ability, placing residents at risk of harm of choking and/or aspiration. Findings include: All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Resident #4: Review of Resident #4 ' s dining guidelines revealed resident has mild oral dysphagia with open mouth carriage and reduced oral motor skills. He takes food, eats and drinks large amounts rapidly especially with favored foods. He is at moderate risk for choking and aspiration. Adaptive equipment included using a straw for slow drinking. Management during meals included reminding him to put his fork/spoon down between bites and wait if he started to eat too fast; use gestures, physical prompts to slow	W 460	Dietary Department will assure that food is cut up into small, manageable bite size pieces for those clients with a Nutritional Management Plan requiring small pieces of food. The Occupational Therapist will provide a template to the Food Service Manager and Attendant Counselor Managers showing the appropriate size the food should be cut, as well as healthy serving size. The Food Service Manager will in turn provide this information to the Dietary staff. Attendant Counselor Managers will post the template diagram in dining rooms for Attendant Counselors to refer to. All Nutritional Management Plans will be reviewed and updated as needed, starting with the three homes in which the sample residents live. The Occupational Therapist will in-service Attendant Counselors on cutting food into manageable bite size pieces. Attendant Counselors have been directed to cut food to manageable bite size pieces when food is not offered pre-cut. The Attendant Counselor Manager will work closely with the Occupational Therapist and Speech	

ABaugh
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W 460	Continued From page 29 his rate of in-take down. Feeding guidelines included small bites of food/drink. Staff were to make sure food was cut up into bite size pieces, including bread. Provide small amounts of liquids to reduce rate of drinking. Observation of breakfast on 03/10/14 revealed Resident #4 was given whole chicken nuggets. Resident #4 grabbed the pitcher of water and proceeded to fill up his water glass as he drank through his straw while continuing to fill glass with water. Resident was able to drink half of the pitcher of water before staff entered the dining area and intervened. During this meal time staff failed to cut food, prompt resident to slow his rate of food and drink intake and provide small amounts of liquid as directed on dining guidelines Observation of dinner on 03/12/14 revealed Resident #4 was given whole chicken nuggets and tator tots (some mashed and some left whole). Resident was provided a glass of juice and 3 - ½ pint containers which included skim milk, 1% milk and chocolate milk. Resident was able to place one to two whole chicken nuggets in mouth and several tator tots, finishing meal within 2 minutes. Resident was able to drink all beverages within one minute, failing to use a straw. During this meal time staff failed to cut food, prompt resident to slow his rate of food and drink intake, provide small amounts of liquid and provide a straw as directed on dining guidelines. Resident #7: Review of Resident #7 dining guidelines revealed resident has mild oral dysphagia with reduced chewing and tongue mobility and pocketing. She eats and drinks with some spillage. She tends to take multiple bites before swallowing the previous bite. She is at mild to moderate risk for choking and aspiration. During the meal staff are to cut all	W 460	Therapist to assure that the Attendant Counselors have been trained on the dining scenario and have a clear understanding on how to safely supervise meals. A Meal Observation form will be used as a monitoring tool and has been revised to include the above topics. Copies of completed Meal Observation forms will be given to the DDA1 and Attendant Counselor Managers for review. Attendant Counselors will sign a training form indicating they have been trained and understand the above issues. Target Completion Date: 5/14/14 Person Responsible: PAT A Director	

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W 460	Continued From page 30 food to small bite size pieces. Cue her to chew and swallow food in her mouth. Avoid putting too much food on her plate. Review of Employee In-service Outline on Goals for Feeding revealed bite size pieces are ½ inch or approximately the size of your thumbnail. Observation on 03/12/14 revealed staff cut Turkey Wrap Hot dog into approximately 1 to 1 ½ inch pieces. Resident #7 was observed taking huge bites. During this meal time staff failed to cut food to appropriate bite size pieces and failed to cue resident during mealtime as directed on dining guidelines. Resident #25: Record review revealed Resident #25 was on a 1600-1800 calorie Dysphagia Advanced Diet with thin liquids. She had a Clinical Swallow evaluation on 12/10/13 that demonstrated she had oral motor problems including limited chewing, chewing with mouth open, rapid eating, pocketing food, and stealing food. Staff were to provide enhanced dining with verbal and physical cues to slow the rate of eating. Staff were to make sure that food was cut up into bite size pieces including bread. She was to have all her food cut up including canned fruit to ¼ inch size. Food was to be moistened with broth and she was to avoid sticky textures and to alternate liquids with food. Observation on 03/11/14 at dinner revealed Resident #25 grabbed 2 unmoistened bread rolls and quickly which she placed in her mouth. During this meal time staff failed to provide a dysphagia advanced diet as directed on dining guidelines. Interview with Staff D revealed she was aware she had forgotten to cut up and moisten Resident #25 ' s bread before she ate it. Resident #26:	W 460		

Keough 5/16/14

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W 460	Continued From page 31 Record review revealed Resident #26 was a Dysphagia Mechanical Diet with thin liquids. She had a Clinical Swallow evaluation on 03/13/13 that demonstrated moderate oral pharyngeal dysphagia with her having missing teeth, low tone, spillage, reduced tongue mobility with some thrusting, decreased lip seal on a cup, and uncoordinated delayed swallow. She takes large bites and eats rapidly and is distractible and vocalizes during meals and is a high risk for choking. Staff were to cue her to take small bites and all food was to be cut into bite sized pieces including bread. Observation during dinner meal on 03/ 11/14 revealed Resident #26 was served French fries which were not on her diet and were not cut into the bite size pieces. During this meal time staff failed provide a dysphagia mechanical diet as directed on dining guidelines.	W 460		
W 471	483.480(b)(1)(ii) MEAL SERVICES Each client must receive meals with not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 1 of 13 sampled residents (Resident #13) and 3 of 21 expanded sampled residents (Resident #16, 25 and 29) received the correct portion size for the diet prescribed. This failure placed residents at risk of receiving incorrect portions for diets prescribed, potentially causing a change in their overall health status.	W 471	Fircrest believes that each client receives meals with not less than 10 hours between breakfast and the evening meal of the same day but recognizes that the current version of Appendix J incorrectly lists the facility practice for W472, which is the appropriate quantity of food, under W471. New serving spoons have been ordered that will indicate the ounces of the food. Staff will be taught how to use the spoons to measure the required amount for each client. Clients who have no dietary restrictions related to portions will be allowed to have more food after the initial serving is eaten.	

Approved 5/16/14

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W 471	Continued From page 32 Findings include: All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Observation revealed the facility main kitchen sends a diet slip with each meal which directs staff as to portion sizes prescribed by dietician. Observation of Unit 320 revealed staff assisting residents with serving unmeasured food portions (using an extra-large flat serving spoon) and failing to follow diet slip for dinner meal on 03/11/14. Resident #13: Review of dietary record revealed that Resident #13 was on a 1200 calorie, high fiber, and dysphagia mechanical diet due to decreased mobility. Observation on 03/11/14 of dinner meal revealed Resident #13 received several extra-large spoonful ' s for the pureed turkey pot pie, one extra-large spoonful of biscuit (pudding consistency), one extra-large spoonful of ground peas and carrots and two extra-large spoonful ' s ' of pureed bananas and oranges. When resident had completed her meal she had seconds on the turkey pot pie and fruit. Review of Resident #13 ' s dietary slip that came from the kitchen revealed that resident was to receive ½ cup of pureed turkey pot pie; 1 biscuit, ¼ cup ground peas and carrots and a ¼ cup of pureed bananas and oranges. Resident #16: Review of dietary record revealed that Resident #16 was on a Dysphagia, high fiber mechanical diet with nectar thick liquids. Observation on 03/11/14 of dinner meal revealed Resident #16 received one and a half extra-large	W 471	In order to assure that clients receive the correct portion of food, staff may have to spoon out the correct amount of food for some clients who are not able to correctly spoon out the identified amount of food. The client can then assist with the remaining part of serving the meal. Attendant Counselor Managers (ACM) will conduct meal observations and check to see if staff are providing the correct amount of food and provide immediate feedback to staff. Duty office staff will also conduct observations and provide information to the ACMs on the observation. Target Completion Date: 5/14/14 Person Responsible: PAT A Director	

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W 471	Continued From page 33 spoonful ' s of pureed turkey pot pie, one extra-large spoonful of biscuit, one extra-large spoonful of peas and carrots and one extra-large spoonful of bananas and oranges. Review of Resident #16 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup ground peas and carrots, and ½ cup pureed bananas and oranges. Resident #25: Review of dietary record revealed that Resident #25 was on a 1600-1800 calorie Dysphagia, Advanced diet. Observation on 03/11/14 of dinner meal revealed Resident #25 received two extra-large spoonful ' s of pureed turkey pot pie, two biscuits and one extra-large spoonful of pureed peas and carrots. Review of Resident #25 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup pureed peas and carrots, and ½ cup pureed bananas and oranges. Resident #29: Review of dietary record revealed that Resident #29 was on a Dysphagia, mechanical diet, high fiber, diabetic diet, mechanical. Observation on 03/11/14 of dinner meal revealed Resident #29 received two extra-large spoonfuls of turkey pot pie, one and a half extra spoonful ' s of pureed biscuit, two extra-large spoonful ' s ' of peas and carrots and an individualized dessert from the kitchen that was already dished up. Review of Resident #29 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup ground peas and carrots, and ½ cup pureed bananas and oranges. Interview of Staff H, Staff I, and Staff J revealed they had worked with residents and knew how	W 471		

5/16/14

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	50G053	A. BUILDING _____ B. WING _____	03/14/2014

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W 471	Continued From page 34 much food each resident was to have and did not always use diet slips. However Staff D stated they did not have measuring utensils to measure the correct amount of food. Staff H, Staff I and Staff J stated they do encourage residents to serve themselves, however without measuring utensils it is difficult to gauge the accurate measurement of food portions.	W 471		
W 485	483.480(d)(4) DINING AREAS AND SERVICE The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Observation and record reviews revealed the facility failed to ensure 1 of 13 sampled residents (Resident #4) and 1 of 21 expanded sampled residents (Resident #25) were adequately supervised and received needed interventions during meals. This failure placed residents at risk of compromised health including choking and or/aspiration. Findings include: All observations and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Resident #4: Review of Resident #4 ' s dining guidelines revealed resident had mild oral dysphagia with open mouth carriage and reduced oral motor skills. He takes food, eats and drinks large amounts rapidly especially with favored foods. He is at moderate risk for choking and aspiration.	W 485	Dietary Department will assure that food is cut up into small, manageable bite size pieces for those clients with a Nutritional Management Plan requiring small pieces of food. The Occupational Therapist will provide a template to the Food Service Manager and Attendant Counselor Managers, showing the appropriate size food should be cut, as well as healthy serving size. The Food Service Manager will in turn provide this information to the Dietary staff. Attendant Counselor Managers will post the template diagram in dining rooms for Attendant Counselors to refer to. All Nutritional Management Plans will be reviewed and updated as needed starting with the three homes in which the sample residents live. The Occupational Therapist will in-service Attendant Counselors on cutting food	

Approved 5/16/14

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W 485	Continued From page 35 Adaptive equipment included using a straw for slow drinking. Management during meals included reminding him to put his fork/spoon down between bites and wait if he started to eat too fast; use gestures, physical prompts to slow his rate of in-take down. Feeding guidelines included small bites of food/drink. Provide small amounts of liquids to reduce rate of drinking. Observation of breakfast on 03/10/14 revealed Resident #4 was given whole chicken nuggets. Staff did not cut food as directed on dining guidelines. Resident was left unsupervised and placed one to two whole chicken nuggets in mouth. Resident #4 then grabbed the pitcher of water and proceeded to fill up his water glass as he drank through his straw while continuing to fill glass with water. Resident was able to drink half of the pitcher of water before staff entered the dining area and intervened. Resident was left unsupervised at dining table for 7 minutes. Observation of dinner on 03/12/14 revealed Resident #4 was given whole chicken nuggets which staff failed to cut into bite size portions, and tator tots (some mashed and some left whole). Resident was also provided a glass of juice and 3 - ½ pint containers which included skim milk, 1% milk and chocolate milk. Resident was left unsupervised at dining table for 5-7 minutes and during that time he was able to place 1-2 whole chicken nuggets in his mouth. Resident ate his entire meal in less than 2 minutes. Resident was able to drink all beverages within one minute, failing to use a straw. Resident #25: Record review revealed Resident #25 was on a 1600-1800 calorie Dysphagia Advanced Diet with thin liquids. She had a Clinical Swallow evaluation on 12/11/13 completed by Speech Language Pathologist. Resident #25 demonstrated oral	W 485	to manageable bite size pieces. Attendant Counselors have been directed to cut food to manageable bite size pieces when food is not offered pre-cut. The Attendant Counselor Manager will work closely with the Occupational Therapist and Speech Therapist to assure that the Attendant Counselors have been trained on the dining scenario and have a clear understanding on how to safely supervise meals. A Meal Observation form will be used as a monitoring tool and has been revised to include the above topics. Copies of completed Meal Observation forms will be given to the DDA1 and Attendant Counselor Managers for review. Attendant Counselors will sign a training form indicating they have been trained and understand above issues. Target Completion Date: 5/14/14 Person Responsible: PAT A Director	

5/16/14

STEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 485	Continued From page 36 motor problems including limited chewing, chewing with mouth open, rapid eating, pocketing food, and stealing food. Staff were to provide enhanced dining with verbal and physical cues to slow the rate of eating. Staff Instructions for Resident #25 ' s PBSP (12/10/13) revealed staff need to be next to resident during the entire meal. Staff were to provide verbal/physical cues to slow her rate of eating and to remind resident to swallow before taking the next bite. She is to be encouraged to place her fork down, and drink a few sips of water throughout the meal. Observation on 03/11/14 at dinner revealed two staff sitting with two 1:1 supervised residents, one staff member serving the residents and one staff member supervising six residents at the table. During this meal Resident #25 grabbed 2 bread rolls which she quickly placed in her mouth one at a time while staff member assisted another resident. Staff failed to notice resident grab the bread rolls and failed to intervene.	W 485		
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each resident was provided an opportunity to promote independence with their dining experience on 6 of 18 units (Unit 307/308, 315/316 and 319/320). This failure did not allow residents the opportunity for skill development. Findings include:	W 488	All PAT A staff providing support to client meals (AC and ATS staff) will be provided training on allowing for client learning and independence during meals. The only exception will be the dishing out of portions for clients who aren't able to learn this skill. Attendant Counselor Managers (ACM), Habilitation Plan Administrators (HPA) and the Developmental Disabilities Administrator 1 (DDA 1) will conduct meal observations and monitor for the promotion of independence. Immediate feedback	

5/16/14

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W 488	Continued From page 37 All observations, record reviews and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Observation at 06:45 am on 03/10/14 of unit 308 and 3:30 pm on 03/12/14 of Units 307/308 dining room revealed staff had set tables with napkins, drinking cups/glasses, and utensils. Observation at 06:30 am on 03/10/14 of Unit 315/316 dining rooms revealed staff had set the tables with drinking cups, utensils and napkins. Observation at 5:00 am on 03/10/14 of Unit 319/320 ' s dining rooms revealed tables were set with dicem (a mat that keeps plate from sliding on table), napkins, drinking cups/glasses, utensils, clothing protectors, and condiments. Plates were on the side table near the crockpots. Interview with Staff D revealed staff set the tables for every meal: The AC staff in charge of the meals were assigned duties to ensure the tables were set with everything except the plates or bowls. When asked why staff were setting tables Staff D stated this was the way it had always been done. Staff H stated during interview on 03/12/14 she does try to have residents assist setting the table, however either they refuse or when they are in dining room they want to eat right away and it is difficult for staff to get the meal ready in time. Record review revealed that per unit and Active Treatment Program Guidelines residents are to pick up their place settings (as able), find a seat at the table (as able) and serve themselves from bowls or trays with staff taking time to individually offer choices.	W 488	will be given to staff. Duty office staff will also conduct observations and provide information to the ACMs on the observation. Target Completion Date: 5/14/14 Person Responsible: PAT A Director	

5/16/14

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

May 8, 2013
CERTIFIED MAIL (7007 1490 0003 4201 3438)

Asha Singh, Superintendent
Fircrest School PAT A
15230 - 15th Avenue NE
Shoreline, Washington 98155

RE: Recertification Survey
4/13/2013 - 4/17/2013

Dear Dr. Singh:

From April 13, 2013 through April 17, 2013, ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Leida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Fircrest School PAT A from 04/13/13 through 04/17/13. A sample of 12 residents was selected from a census of 124. The expanded sample included 57 current residents. The survey was conducted by: Penelope Rarick, B.A. Terry Patton, R.N., B.A. Janette Buchanan, R.N., B.A Claudia Baetge, M.A. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Services Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2405 Fax: (360) 725-2642	W 000	**W104** – All staff on units 301-302, 311-312, 313, 317 and 319-320 have been retrained in the proper labeling and storage of food items on unit: All food items must be labeled with open/received date and disposal date. All opened items must be stored in airtight containers. Airtight storage containers and Ziploc bags have been made available in the Fircrest commissary for easy ordering. ACMs will make twice-weekly inspections of all food storage locations to ensure compliance. All unlabeled or improperly stored foods will be discarded upon discovery. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure proper food handling and storage and failed to provide a well repaired and hazard-free environment in 8 of 18 Units. Failure to store and handle food properly placed residents at risk of foodborne illness and failure to	W 104	**W104** – All AC staff in PAT A have been retrained in the proper labeling and storage of food items on unit: All food items must be labeled with open/received date and disposal date. All opened items must be stored in airtight containers. Airtight storage containers and Ziploc bags have been	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Benoit — TITLE: Asst. Supt. — (X6) DATE: 5/29/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 provide a well repaired and maintained environment placed residents at risk for harm and injury. Findings include: All observations and interviews were between 4/13/13 and 4/17/13 unless otherwise stated. Observations of kitchens were not completed on all units. Observations of Unit kitchens, Main kitchen and other storage units revealed, but were not limited to, the following: Unit Kitchens and Pantry Areas Kitchen refrigerators, freezers, cupboards and pantry areas of Unit 301, 302, 311, 312, 313, 317, 319, and 320 contained food items that were past the expiration dates and contained food items that were opened, unlabeled and undated. Facility Main Kitchen Kitchen cooking area 1. Variety of spices, no open date 2. Metal pitcher with unknown substance 3. Canola oil, no open date 4. Basket with misc. items and cooking utensils: 3/4 measuring cup, 1/3 measuring cup, black clips, wound wipes, alcohol prep., post-its Main Walk-in Freezer	W 104	airtight containers. Airtight storage containers and Ziploc bags have been made available in the Fircrest commissary for easy ordering. ACMs will make twice-weekly inspections of all food storage locations to ensure compliance. All unlabeled or improperly stored foods will be discarded upon discovery. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A – AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent **W104** – Fircrest Main Kitchen will ensure food is handled properly, to ensure the health and safety of the clients and to keep clients safe from food borne illness by: • Re-In service dietary staff on food guidelines regarding closing and storage of open food, labeling and dating. • Food Service employees have been directed to initial food items when labeling and dating food to assist with accountability. • Cook 3 will do an environmental check list at the beginning of each day.	

Brad Benoit 5/29/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 104	Continued From page 2 1. Sorbet, expired 3/2/13 2. Pork sausage patties, (labeled pureed) in box, exposed to air, no open date 3. Dinner rolls (3), no open date 4. Whole wheat hot dog buns (5), no open date 5. Cakes on large tin pan (2), partially exposed to air, unlabeled, no date 6. Pizza (3), no open date 7. Bag of blueberries, no open date 8. Cupcakes in Ziploc bag (5), unlabeled, no open date 9. Chicken in Ziploc bag, unlabeled, no open date 10. Turkey meat in box covered with plastic wrap, exposed to air, freezer burn, no open date. 11. Boneless ribbed shaped patties, exposed to air, freezer burn, no open date 12. Meat (?), exposed to air, freezer burn, no open date 13. Sausage links, box (2), exposed to air, no open date Storage area 1. Bottle with prescription medication (belonging to staff person) on storage shelf 2. Tasteeos cereal (14 bags), expired 10/24/12 Pantry (walk-in) 1. Real Mayo, 16.5 oz, no open date 2. Caesar Dressing (1 gallon), no open date 3. Pourable Blue Cheese, no open date 4. Milk (2 gallons), expired 4/9/13 Refrigerated Unit 1. Coffee Mate Creamer, no open date 2. International Delight coffee creamer, no open date	W 104	• Food service supervisor will do environmental check list at the end of each day. • Environmental check lists will be turned into Food Service Manager each day. Food Service Manager will monitor by doing a walk through each morning upon arrival to ensure food is stored properly. • Main Walk-in Freezer has been cleaned and organized. • All food in freezer improperly sealed or out dated has been discarded. • Food Service Manager will update the procedure on Pulling Food from Freezer, adding an inventory component pulling the older dated food forward upon arrival of the new food order. Cook 3, Cook 2, Morning Cook and Food Service supervisors and warehouse worker will be in-serviced on updated procedure. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Elisabeth Thompson, Food Services Manager Brad Benoit, Assistant Superintendent W104—Warehouse employee was reassigned to commissary when Prescription medication was found on	

Brad Benoit 5/29/13

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W 104	Continued From page 3 Upright Freezer 1. Pizza in Ziploc bag, unlabeled, no open date 2. Hamburger patties, unlabeled, no open date 3. Bag of French fries, no open date 4. Bag of tater tots, no open date 5. Bag of chicken breasts, no open date 6. Individual portions of rice (2), no open date 7. 1 gallon barbeque sauce, spilled over sides Unit Bathrooms Bathrooms in Units 303, 304, 308, 313, and 319 had no toilet paper available to residents. Bathrooms in Units 311, 314, 316 and 320 had toilet paper out of reach for residents that were either placed on the windowsill, on bathroom counter or in bathroom drawer. Bathrooms in unit 317 had toilet paper locked in cabinet and not accessible by residents. Laundry 1. Unit 305- Clean laundry was placed on the floor outside residents' rooms. 2. Unit 317/318- Six stacks of clean clothing were on the floor in the laundry room. 3. Unit 320- A pair of damp black TED hose had been placed on the floor HVAC vents. Staff revealed the TED hose had been washed by hand and were laying on the floor vents to dry. Interior/Exterior	W 104	shelf in storeroom near food. The warehouse employee is supervised by CIBS not Fircrest. CIBS Management completed an investigation of the incident and will be addressing the matter via performance feedback with the employee. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Jena Richmond, CIBS Procurement/Supply Manager Brad Benoit, Assistant Superintendent **W104** – (Unit bathrooms) ACM's have given documented expectations to AC staff that they are to ensure that toilet paper is always available in the bathroom. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent **W104** – (Laundry) ACM's have given documented expectations to AC staff that they no laundry is to be stored on the floor or dried on floor vents. Staff will put laundry away properly. Each shift	

Brad Benoit 5/29/13

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W 104	Continued From page 4 Interior Units 1. Unit 301- Missing handles on cabinet in dining area 2. Unit 302- Burned out bathroom light 3. Unit 302- Wall tile was hanging off the wall between rooms 13A and 13B. 4. Unit 306- The toilet in bathroom #10 had water leaking from the base, creating a small puddle on the floor. 5. Unit 320- A plastic tub had been placed in the middle of the living area to catch water from a leak in the ceiling. The leak had not been reported to the maintenance department. 6. Unit 320- Water was leaking through the vent above the toilet in bathroom #10. Exterior Units Bags containing dirty laundry had been placed in the outside storage containers designated to hold the dirty laundry on Units 302, 303/304, 311/312, 313/314 and 317/318. The storage units did not have the capacity to hold the volume of laundry causing the container doors to not stay closed. It was observed that over the period of several days the laundry bags fell out of the storage containers and remained scattered on the ground near the entrance of the units. Used food trays from the main kitchen, one still containing food, had been left outside for several hours near the entrance to Unit 317/318.	W 104	charge will check to ensure that laundry is stored properly. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent **W104** – (Interior Units) ACM's have completed work orders for the following repairs to be done: • 301 –missing handles in dining area • 302 – burned out bathroom light • 302 – wall tile hanging off wall between Rooms 13A & 13B • 306 – the toilet in bathroom #10 leaking near base • 320 – roof leak • 320 – water leaking through the vent in Bathroom #10 **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** All PAT A ACM's Brad Benoit, Assistant Superintendent **W104** – Each ACM will review the procedure and form to get maintenance repairs done in the home with all AC staff. AC staff will be instructed to complete these forms when they observe something which needs to be fixed, repaired.	
W 116	483.410(c)(6) CLIENT RECORDS The facility must provide each identified residential living unit with appropriate aspects of	W 116	**COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** All PAT A ACM's Brad Benoit, Assistant Superintendent	

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W 116	Continued From page 5 each client's record. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff had access to the most current and relevant information for 5 of 12 sampled residents (Resident #3, 5, 7, 8 and 11) and 3 of 57 expanded sample residents (Resident #31, 36 and 41). Failure caused staff to be unaware of a residents ' functioning level, medical issues, restrictive practices and dietary needs. Findings Include: All record reviews and interviews were completed between 4/13/13 and 4/17/13 unless otherwise stated. The PBSB ' s found in Resident #5, 7, 8, and 11 medical/behavioral charts were outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. The CFA/IHP found in Resident #41 ' s chart was outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. The PBSB ' s found in Resident #3, 8, 11 and 36	W 116	**W104** – (Exterior units) The outside plastic storage units designated to hold dirty laundry have been determined to be inadequate for the purposes of holding dirty laundry. Each home on PAT A will receive a new, more robust, and sturdier storage container for dirty laundry. **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** All PAT A ACM's Brad Benoit, Assistant Superintendent **W104** – (Exterior units) ACM's have given documented expectations to AC staff that when/if food trays are outside the home the trays will be clean and clear of all food. Each shift charge will be responsible for making sure that the exterior of the home is sanitary. AC staff have signed training forms on this issue. **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** All PAT A ACM's Brad Benoit, Assistant Superintendent **W116** – (Client Records) SOP I.B.06 (Role of ID Team) clearly indicates that it is the HPA's role to keep the client's chart current. Each HPA will review this SOP and review these expectations with their supervisor. HPAs will ensure each client chart is current. **COMPLETION DATE:** 5/31/13	

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W 116	Continued From page 6 program charts were outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. The IHP found in Resident #5 ' s program chart was outdated and from a previous facility. The updated CFA/IHP had not been filed in program book. The current Staff Guidelines were not found in Resident #31 ' s program book. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. Interviews with facility staff revealed Program Books are used by direct care staff to identify any resident information including dietary needs, restrictive interventions, and program plans. Staff are expected to document program data in the program book. Staff interviews revealed staff ask co-workers for resident information when program books are not up to date.	W 116	**PERSON(S) RESPONSIBLE:** Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent **W116** – (Client Records) Each ID Team has been instructed to review all client's charts/program books to ensure that each record contains all the most recent versions of treatment plans (CFA/IHP/PBSP/Profiles/Staff Instructions/Training Programs). **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by:	W 148	**W148** – (Communication) HPAs will review existing consents and note for which situations parents/guardians want notification. Parents/guardians will be notified according to their preference. HPA's are responsible for all non-medical notifications according to preferences the guardian has identified on the consents. HPA's will review this expectation with their supervisor. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Debbie Kruse, DDA1	

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W 148	Continued From page 7 Based on record review and interviews, facility failed to notify parents/legal guardians for 2 of 12 residents (Resident #3 and #10) regarding significant events involving harmful behaviors and use of psychotropic medications. Failure prevented parents/guardian from receiving immediate knowledge of significant incidents which may impact resident ' s physical health and safety. Findings include: All record reviews and interviews were completed between 4/13/13 and 4/17/13 unless otherwise stated. Interview with Resident #3 ' s parent/guardian revealed that parent had not been notified when resident received STAT medications on 03/15/13, was placed in physical restraints on 03/15/13, 03/24/13 (x2), and had exhibited recent behavioral episodes on 03/24/13. Resident #3 ' s parent signed Consent and Service agreement stating he wanted to be informed of all incidents that occurred with resident. Review of Resident #10 ' s records revealed Resident #10 parent/guardian had not been notified when resident received 1 milligram [redacted] by mouth at 4:00 PM and again at 7:45 PM on 04/12/13. Nursing notes revealed [redacted] was given for resident ' s agitated behavior. Resident #10 ' s documentation revealed guardian had not given consent for [redacted] (or related drug) for behavioral control. Consent and Service	W 148	Brad Benoit, Assistant Superintendent **W148** – (Communication) According to SOP I.B.06 (Role of Interdisciplinary Team), the Heath Care Coordinator is the designated person with the primary role to: "*Inform guardians of accidents that result in injuries that have the potential for requiring physician intervention, such as falls, significant changes in client condition, need to alter treatment significantly, or commence a new treatment. Communicates appointments as requested by the guardians and documents guardian conversations/notifications in the Health Care Notes.*" Thus, all Health Care Coordinators will review SOP# I.B.06 and be instructed by their supervisor to follow this procedure with specific emphasis placed on guardian notifications. **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** Frankie Jackson, RN 4 **W148** – (Communication) SOP I.A.07 (Psychoactive Drug Usage) - Nursing	

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W 148	Continued From page 8 agreement signed 2/10/13 by guardian revealed the facility would keep him informed of Resident #10 ' s status.	W 148	Procedure I.I.5 will be modified to ensure that in instances of emergency use of psychoactive medications: "*The nurse administering the medication will notify the client's guardian of the medication given, the reason the medication was given and the client's response and condition after the medication was given.*" All nursing staff will be in-serviced on this change in nursing procedures: **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** Frankie Jackson, RN 4	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and records review, the facility failed to appropriately assess, update and make relevant Positive Behavioral Support Plans (PBSP) for 1 of 12 sampled residents (Resident #3) and 1 of 57 expanded sampled residents (Resident #13) in relation to the resident ' s behavioral management needs. This failure placed residents at risk of harm due to staff ' s inability to implement necessary supervision and protection. Findings include: All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13. Observations, interviews and record review revealed conflicting information regarding the supervision of Resident #3. Resident #3 ' s. program book revealed a PBSP, dated 10/16/12, which stated supervision of Resident #3 should be two staff for one resident (2:1). In the same program book the Directions to Staff, dated 09/27/12, stated supervision would be one staff for one resident (1:1) Resident #3 ' s Personal Profile state supervision would be one staff to three residents (1:3).	W 214	**W214** - HPA's (with assistance from the rest of the ID Team) will check all Personal Profiles to ensure all are updated and current. Once personal profiles are considered current, AC staff will be trained on Personal Profiles. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent **W214** – IDT (lead by HPA) will review all people receiving enhanced supports (i.e. 1:1, 2:1, etc.) to ensure that the most current established supervision requirements are characterized	

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W 214	Continued From page 9 Observation of Resident #3 revealed no staff providing direct supervision. Resident was sitting in a lounge chair talking with State Surveyors as staff assisted other residents. Interview of HPA revealed Resident #3 was 1:2 (one staff for 2 residents) and had not been 2:1 or 1:1 for a long period of time. During the state survey the unit psychologist added hand written notes to the Directions For Staff section of Avoidance Procedures and stated the resident does not have one-to-one supervision, never the less, implement all the instructions under one-to-one supervision. HPA and psychologist agreed that the by failing to update PBSP, Directions to Staff, and the Personal Profile staff would have difficulty knowing how to care for the resident. Observation on 4/13/13 (night shift) revealed no staff were within line of sight of Resident #13 but one staff may have been within hearing distance. On 4/13/13 (day shift) a staff was observed staying within arm length of Resident #13. On 4/14 /13 (evening shift) staff were observed keeping Resident #13 within line of sight. Record review of Resident #13 revealed several documents with conflicting information. Positive Behavior Support Plan (PBSP) section, a document dated 2/2/11 " Guidelines for the two staff required to work with Resident #13 " identified in all locations two staff must be with Resident #13 (2:1 monitoring ratio) and one of those staff must be within arm length of Resident #13 to prevent her from harming herself. The	W 214	consistently throughout each care plan. The IDT will also review the 1:1 supervision instructions for AC staff to ensure that they are clear, specific, and lack ambiguity. Once it is assured that the 1:1 supervision requirements are clear/specific and consistently documented across all care plans, the IDT will train all AC staff assigned to the home on the supervision requirements. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent W214 –All PBSPs, PBSP Staff Instructions will all consistently reflect the appropriate level of supervision that is necessary to keep the individual and others safe in various environments. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist	

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W 214	Continued From page 10 same section of Resident #13 ' s record revealed a PBSP dated 12/15/11 which had one staff monitoring Resident #13 (1:1 ratio). The PBSP noted that if a 1:1 staff is scheduled the staff will be near Resident #13 at all times and work only with Resident #13. The PBSP found in Resident #13 ' s program Book, which is used by staff to record data pertaining to Resident #13 ' s program, was dated 12/8/10. Interview with staff revealed inconsistencies in their understanding of Resident #13 ' s plan to protect Resident #13. A night shift supervisor revealed 1 staff could monitor up to 3 residents (1:3 staff to residents), including Resident #13, within hearing on the night shift. A day shift supervisor revealed she believed 1 staff had to stay within arm length of Resident #13 at all times. The Unit ' s supervisor revealed staff needed to keep Resident #13 within line of sight.	W 214		
W 251	483.440(d)(3) PROGRAM IMPLEMENTATION Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the Positive Behavioral Support Plan and implement appropriate supervision for 1 of 57 expanded sample residents (Resident #17). This failure placed resident at risk for unmet medical and	W 251	**W251** – IDT (lead by HPA) will review all people on PAT A receiving enhanced supports (i.e. 1:1, 2:1, etc.) to ensure that the most current established supervision requirements are characterized consistently throughout each care plan. The IDT will also review the 1:1 supervision instructions for AC staff to ensure that they are clear, specific, and lack ambiguity. Once it is assured that the 1:1 supervision requirements are clear/specific and consistently documented across all care plans, the IDT will train all AC staff assigned to the home on the supervision requirements. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:**	

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W 251	Continued From page 11 care needs. Findings include: On 04/13/13 at 4:34 a.m. observation of Resident #17 asleep in bed in his room, his bedroom door pulled shut. Further observation revealed two staff on night shift; one sitting on couch in living room area and second staff walking down the hallway connecting Unit 312 and 311. On interview, the two staff revealed Resident #17 was on enhanced supervision due to behavioral concerns. They reported that supervision could be provided while positioned in the living room. Review of Resident #17 's PBSP revealed a staffing ration of 1:1 and directions for night shift included visual supervision to monitor for seizure activity. Resident #17 has a seizure disorder and a Vagus Nerve Stimulator (VNS) implanted to assist in the management of his seizure activity. VNS is used to prevent seizures by sending regular, mild pulses of electrical energy to the brain via the Vagus nerve. If the regular interval electrical pulses do not prevent a seizure, a magnetic wand can be used to deliver an extra pulse of stimulation. This extra electrical stimulation can stop the seizure, shorten the seizure, or reduce the seizure severity. The unit Attendant Counselor 3 reviewed the PBSP and reported resident ' s door should be left open and staff should be positioned outside of the door and have the resident within their line of sight, during the night shift. Observation at 4:34 a.m. on 04/13/13 revealed the door was not left open and staff were not positioned to provide the necessary line of sight supervision of the resident.	W 251	Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent	
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262	**W262** – Resident # 13 will have the addition of Lorazepam reviewed by the Human Rights Committee. Resident #31 will have the addition of Oxcarbazepine reviewed by the Human Rights Committee. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Debbie Kruse, DDA 1 Brad Chang, Chief Psychologist **W262** – The IDT will cross-check all psychotropic medications given with consents/HRC approvals of PBSP Medication plans to ensure that each psychotropic medication currently being administered has received the proper	

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W 262	Continued From page 12 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record reviews and interviews facility failed to ensure the Human Rights Committee (HRC) reviewed, approved, and monitored all programs which utilized restrictive techniques for 2 of 57 expanded sample residents (Resident #13 & 31). This failure allowed resident to be given medications to manage behavior before HRC had given consent and has violated the rights of these Residents. Findings include: Resident #13: Records review on 4/13/13 revealed [redacted] (a psychoactive medication that affects behavior) 1 mg twice a day was ordered by a physician to start on 8/2/12. Review of the Medication Administration Records revealed Resident #13 has received [redacted] mg. as prescribed, since 08/2/12. Interview on 4/16/13 with the facility's supervising Psychologist revealed the Human Rights Committee had not approved a program for Resident #13 using [redacted] as ordered or any similar medication. Resident #31: Records review on 4/15/15 revealed a 2/13/13 physician order for [redacted] (a	W 262	guardian consent and HRC review/approval. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Debbie Kruse, DDA 1, Brad Chang, Chief Psychologist Brad Benoit, Assistant Superintendent **W262** - Medical providers, Pharmacy staff, HCC's, HPA's, Psych's, QA staff will be in-serviced on the following protocol related to psychoactive medication: • For all <u>new</u> psychoactive medication prescriptions: 1. Medical providers will assist IDT with justifications for the start of a new psychoactive medication. 2. The IDT will present the justifications for the medication and seek consent (30 day emergency telephone consent) from the guardian. QA Department will contact the Chair of the HRC for emergency approval for the use of the new psychoactive medication. 3. The QA Department will notify Pharmacy when the guardian's emergency consent and the emergency HRC Chair's approval have occurred for the medication. 4. Upon this notification from QA, the Pharmacy will dispense the psychotropic medication prescription. 5. The medication plan, which is an Addendum to the PBSP, and an updated	

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W 262	Continued From page 13 psychoactive medication that effects behavior) 300 mg by mouth twice a day for 1 week, then, after the first week, increased to [redacted] 600 mg. by mouth two times daily. Review of the Medication Administration Records revealed Resident #31 has received the [redacted] as prescribed, since 2/12/13. Interview on 4/16/17 with the Habilitation Plan Administrator revealed the Human Rights Committee has not approved a program for Resident #31 using [redacted] or any similar medication.	W 262	written informed consent, will be presented to the HRC for review/approval. The PBSP-Medication Plan Addendum and the Informed Consent will be sent to the guardians for their approval and consent. • For current psychotropic medications: 1. QA Department will provide Pharmacy with current consents for medication labels.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews facility failed to obtain written consents prior to implementation of restrictive programs in regards to locking resident bedroom doors, locking grooming/hygiene items and locking sharp knives/items, in 5 of 18 units. Failure to obtain written consents denied the resident/guardian the opportunity to make informed decisions about facility restrictive programs. Findings include: All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13. Unit 311 Resident #5 and #24 bedroom doors were locked and residents were unable to enter	W 263	2. Pharmacy will publish a 30-day notice when consents are due to expire as a tickler to the IDT for tracking purposes. 3. All labels for psychoactive medications will display the expiration date for the consent for the current prescription. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Frankie Jackson, RN 4 Debbie Kruse, DDA 1 Brad Chang, Chief Psychologist Lura Dunn, QA Director Brad Benoit, Assistant Superintendent Asha Singh, Medical Superintendent **W262** –HPA's and Psych staff will review and sign an in-service form on SOP I.A.07 (Psychoactive Drug Usage), which specifically addresses consents and HRC approval requirements for the use of psychoactive drugs (Section: Use of	

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W 263	Continued From page 14 their rooms without asking staff for assistance. Unit 312 Resident #6, #14, and #18 bedroom doors were locked and residents were unable to enter their rooms without asking staff for assistance. Unit 313 Resident #7, 19, 20, 21, and 23 grooming/hygiene items were locked in bathroom cabinets. Residents were unable to access items without asking staff for assistance. Units 317/318 Sharp knives were in plastic container sitting on shelf upstairs. The door leading to the stairs was locked, preventing residents from accessing the items. Interviews and document review revealed written consents had not been obtained prior to implementing these restrictive programs.	W 263	Psychoactive Medications – Subsection B). **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** Brad Chang, Chief Psychologist Debbie Kruse, DDA 1 **W263** – (Program Monitoring & Change) Each HPA on PAT A will review SOP I.A.03.1 (Informed Consent) with their supervisor, be instructed to follow the SOP, and sign an in-service form. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent	
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on interview and records review, facility failed to identify and document systematic use of positive alternatives and effectiveness of alternatives, prior to using restrictive techniques (psychotropic medications) for 2 of 12 Residents (Resident #3 and 10). Failure denied residents the opportunity to be provided less intrusive restrictive techniques to manage their behavior.	W 278	W263 – (Program Monitoring & Change) IDT will assess each client's need for restrictive devices and interventions. Written consent from client's parent/guardian will be obtained by the HPA for approval of all restrictive devices or interventions recommended by the IDT. Direct care staff will be trained on implementation of restrictive devices/interventions and sign an in-service form to document the training. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 **W278** – The PBSPs for Client # 3 and Client # 10 will be reviewed by the treating psychologist to ensure that there are proactive positive behavioral	

Brad Benoit 5/29/13

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	50G053	A. BUILDING _____ B. WING _____	04/17/2013

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W 278	Continued From page 15 Record review and interviews revealed Resident #3 had no evidence that resident received the least restrictive restraint technique for his behavioral control. There is no documentation to reflect resident ' s PBSP had been followed to control his behavior. Record review and interviews revealed Resident #10 had no evidence that resident received the least restrictive interventions for his behavioral control. Nursing records revealed Ativan was given for Resident ' s agitated behavior. Resident #10 ' s PBSP showed 4 interventions which should be used to address challenging behaviors. There was no documentation as to whether these least restrictive techniques were attempted or effective prior to Resident #10 receiving Ativan.	W 278	strategies to be implemented in order to avoid the occurrence of challenging behaviors. When challenging behaviors are manifested, the PBSP will provide specific positive intervention strategies progressing from the least intrusive to the most restrictive techniques to be used to keep the individual and others safe from harm or injury. Staff members will be trained by the treating psychologist for Client # 3 and Client # 10 in their PBSP and how to implement positive behavioral strategies and techniques from the least intrusive to the most restrictive interventions for these individuals. Staff members will also be trained to document their positive behavioral support interventions from the least intrusive to the most restrictive on Client # 3 and Client # 10's behavioral logs and on a restraint event report should a restrictive intervention been implemented. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist **W278** - All psychology staff members will review their client's PBSPs, PBSP Staff Instructions and Behavior Implementation Plans to ensure that all have specific positive behavior support strategies that range from the least intrusive to the most restrictive techniques and strategies to be used when	
W 322	483.460(a)(3) PHYSICIAN SERVICES. The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews 4 of 12 sampled residents (Resident #1, 2, 7 and 8) revealed annual physical evaluations had not been done within the last year by a physician. Failure to have an annual physical evaluation placed residents at risk of unidentified medical issues which could lead to deterioration in their overall health. Findings Include: All record reviews occurred between 4/13/13 and	W 322		

Brad Chang 5/29/13

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W 322	Continued From page 16 4/17/13 Resident #1 Annual Medical Review dated 8/10/11 Resident #2 Annual Medical Review dated 4/29/11 Resident #7 Fircrest School History and Physical dated 11/12/2011 Resident #8 Fircrest School Admission History and Physical dated [redacted] 2011	W 322	challenging behaviors are manifested. The psychologist will then train the ACM and AC Charges in the implementation of these individuals' positive behavioral support plans, as well as how to document staff members interventions from the least to most restrictive interventions in the individuals behavior log and on a restraint event report should a restraint be applied. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist	
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record reviews facility failed to complete Quarterly Nursing Assessments for 2 of 12 sampled residents (Resident #8 and #9). Failure to complete Quarterly Nursing Assessments placed residents at risk for unmet nursing care needs. Findings include: All record reviews occurred between 4/13/13 and 4/17/13. Record review revealed Resident #8 had Quarterly Nursing Assessments completed on 2/21/12, 05/30/12 and 10/11/12. A Quarterly Nursing Assessment was not completed in the 3rd quarter during 2012.	W 336	**W322** – Annual medical evaluations for the Clients #1, #2, #7, and # 8 have been completed. Additionally, a directive has been issued to all medical providers to complete all annual medical evaluations on all PAT A clients by 6/14/13. The Medical Director/Superintendent is checking status every week to ensure compliance with the directive. **COMPLETION DATE:** 6/14/13 **PERSON(S) RESPONSIBLE:** Asha Singh, Medical Superintendent **W322** - On first day of every month, each medical provider will be provided with a list of medical evaluation due that month on their case load with the expectation that all medical evaluations will be completed by the end of month. If due to some reason the medical providers	

Brad Brant 5/29/13

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W 336	Continued From page 17 Record review revealed Resident #9 had Quarterly Nursing Assessments completed on 2/28/12, 5/30/12 and 1/17/13. A Quarterly Nursing Assessment was not completed in the 3rd and 4th quarter during 2012.	W 336	are unable to complete the medical evaluations assigned to them by the end of the month, they will notify their supervisor (Medical Director/Superintendent) by 20th of that month. Medical Director/Superintendent will provide necessary assistance to ensure timely completion. **COMPLETION DATE:** 6/3/13 **PERSON(S) RESPONSIBLE:** Asha Singh, Medical Superintendent	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews facility failed to ensure safe hygiene practices were being followed in 5 of 18 Units (Unit 301, 311, 312, 313 and 314). This failure placed residents at risk of being exposed to a communicable disease. Findings Include: All observations and interviews occurred between 4/13/13 and 4/17/13. Observation during the lunch meal in Unit 301 revealed staff did not wash their hands between assisting a resident in taking dirty dishes to the kitchen and then serving up another resident their meal. A staff was also observed assisting a resident with dishing up their meal by performing a hand over hand technique. The staff then performed the same procedure with another resident without washing her hands between assisting each resident.	W 455	**W336** - Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need Quarterly nursing assignments have been reviewed with all PAT A Health Care Coordinators (RN2) staff. Schedules for quarterly health assessments have been made with the expectation that the quarterly assessments will be completed in a timely manner with no exception. Each RN will submit a schedule of completion to the RN 4 by the 20th of each month. RN3/RN4 to conduct chart reviews for compliance. The facility has completed a 100% chart review in this area and identified where there are deficiencies and corrective steps and re-training are in progress and on-going to ensure compliance.	

Brad Benoit 5/29/13

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 455	Continued From page 18 Observation during the dinner meal in Unit 311, 312, 313 and 314 revealed staff failed to wear gloves and/or wash hands after touching food items and/or serving residents by performing hand over hand technique. Interview of staff on Unit 301 verified that they did not wash their hands and were unaware that hands needed to be washed when touching the resident. Another staff member stated that they were not touching the food therefore they did not need to wash their hands. Interview of staff on unit 311, 312, 313 and 314 revealed confusion about the need wear gloves and wash hands. Observations and interviews on Unit [redacted] revealed the facility failed to label two personal electric razors with names for Residents #5 and #24. Observations and interviews on Unit [redacted] revealed the facility failed to label personal electric razors with names for 4 of 6 residents (Resident #15, 16, 17 and 18). Interview of staff on both Unit [redacted] and [redacted] reported they would be unable to determine which resident owned each razor, making it difficult to provide each resident with the correct razor.	W 455	**COMPLETION DATE:** 6/14/13 **PERSON RESPONSIBLE:** Frankie Jackson, RN 4 **W455** – (Infection Control) Staff will be retrained on hand washing procedures between working with individual clients and the use of gloves during meal preparation if staff are touching food without a barrier. Hand sanitizer dispensers have been installed in all PAT A dining rooms and easy-to-use food handlers' gloves will be provided by commissary. AC staff will sign training forms on this issue. **COMPLETION DATE:** 5/31/2013 **PERSON(S) RESPONSIBLE:** PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent **W455** – (Infection Control) ACM's have given documented expectations to AC staff that: All AC staff will look for name on razors when they do client grooming and report to the Shift Charge if label is missing. Additionally, the AM Shift charge will check all razors once a week. If labels are missing, they will make a new one or ask ACM to make a new one. AC staff have signed training forms on this issue. **COMPLETION DATE:** 5/31/13 **PERSON(S) RESPONSIBLE:** All PAT A – AC Managers Brad Benoit, Assistant Superintendent	
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews facility failed to serve food/beverage within 15 minutes of removal from a temperature control device or failed to maintain the appropriate food	W 473		

Brad Benoit 5/23/13

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W.473	Continued From page 19 temperature for 7 of 10 Units (Unit 302, 307, 311, 312, 313, 316, and 318) and 1 Adult Training Program (ATP) facility (Room 88E7-Unit 319/320 Residents). Failure to serve food/beverage promptly resulted in residents being served food/beverage that had not been held at an appropriate temperature creating a potential for foodborne illness. Findings include: All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13. All food temperatures were taken as food was being served to residents. Observation on Unit 302 revealed luncheon food items were being served to residents upon the arrival of the State Surveyors. The temperature of the food was taken and revealed the following: pureed noodles 126°, pureed chicken 120° and vegetables 110°. Observation on Unit 307 revealed dinner food items were being served to residents upon the arrival of the State Surveyors. The temperature of food was taken and revealed the following: fish filet 135°, hamburger patty 130°, peas 84° and squash 95°. Observation on Unit 311 revealed dinner items had been left on counter before serving for over 30 minutes. Food was served to residents without checking temperature and without reheating. The temperature of the food was taken and	W 473	**W473** – (Meal Services) New Aladdin food trays have been ordered to replace older ones that no longer sealed properly. **COMPLETION DATE:** 5/31/2013 **PERSON(S) RESPONSIBLE:** Elisabeth Thompson, Food Services Mngr Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent **W473** - Food thermometers have been supplied to each unit for measuring temperatures to ensure compliance with food temperature requirements per WAC. AC staff have been directed to remove bulk foods immediately upon arrival from the dietary and place them in the oven, pre-heated to 225 degrees, until	

Brad Benoit 5/29/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 473	Continued From page 20 revealed the following: lasagna 121°, chicken 121°. Observation on Unit 312 revealed lunch food items had arrived from main facility kitchen at 4:20pm and were brought into the unit. The foil had been removed from serving containers at 4:45 pm but not served to residents until 5:00 pm. The food had not been reheated before serving residents. The temperature of food was taken and revealed the following: lasagna 122°, mixed vegetables 115°, macaroni and cheese 114°, milk 68°. Observation on Unit 313 revealed lunch food items had arrived from main facility kitchen at 11:15 am and brought into the unit at noon. Foil had been removed from serving containers at 12:05 pm but not served to residents until 12:40 pm. Food had not been reheated before serving residents. Temperatures were taken and revealed the following: pasta 118°, chicken 121°. Observation on Unit 313 revealed dinner items had been sitting for over 40 minutes before being served to residents. Food had not been reheated before serving residents. Temperatures were taken and revealed the following: fish Filet 105°, vegetables 117°. Observation on Unit 316 revealed breakfast sausage links were served at 115°. Observation on Unit 318 revealed noodles served at lunch were 118°. Observation at ATP Room 88E7 (319/320 residents) revealed spaghetti served at lunch was 115°.	W 473	ready for service. Cold items are to be placed in the refrigerator immediately. Buffet warming trays that hold food temperatures between 158 and 185 degrees for up to six hours were ordered for each living unit (4 per duplex) for service of hot foods in the dining room when meal time has been announced. For clients that receive individual trays a microwave has been placed in each dining area to warm their food before serving the individual. AC staff have signed training forms on all these issues. **COMPLETION DATE:** 5/31/2013 **PERSON(S) RESPONSIBLE:** PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent	

Brad Benoit 5/29/13

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W 473	Continued From page 21 Staff interviews revealed staff were unaware of temperature guidelines and reheating expectations when serving food. Staff in seven of the ten observed units were unable to find food thermometers in their kitchens. USDA guidelines recommend food must be reheated to 165 degrees Fahrenheit or above and held above 140 degrees Fahrenheit until served, in order to destroy the bacteria that can cause foodborne illness. Cold food items should be held and served at 45 degrees Fahrenheit or cooler.	W 473		
W 478	483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to provide a variety of foods at each meal for 2 of 18 Units (Unit 302 & 314). Failure to provide alternatives did not give residents a choice of foods. Findings include: Observation of lunch meal on 4/14/2013 revealed residents on Unit 302 (Resident #1, 22, 61, 67, 68, and 57,) were not given the opportunity to choose what they would like to eat that would follow their diet restrictions. Residents were served the meal that was sent from the kitchen. Observation of the lunch meal on 4/14/2013 revealed that no alternative food choices had been offered to residents on Unit 314 (Resident #8, 28, 29 and 30). Alternative food choices had not been prepared by staff. Staff interviews revealed staff found it difficult to prepare alternatives due to only having two staff on shift.	W 478	**W478** - (Menus) Staff on houses 301-302 and 313-314 were re-trained on the policy of preparing at minimum one alternate entree, beverage and dessert choice for each meal and to begin meal prep a minimum of 30 minutes before the arrival of trays and bulk food from dietary, to ensure that sufficient time is available for arranging the choices and pre-heating warming apparatus. **DATE COMPLETED:** 5/31/2013 **PERSON(S) RESPONSIBLE:**	

Brad Benoit 5/29/13

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W 478	Continued From page 22 Staff also revealed the unit was short food selections based on a lack of ordering through the commissary.	W 478	AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent **W478** - (Menus) All PAT A staff were re-trained on the policy of preparing at minimum one alternate entree, beverage and dessert choice for each meal and to begin meal prep a minimum of 30 minutes before the arrival of trays and bulk food from dietary, to ensure that sufficient time is available for arranging the choices and pre-heating warming apparatus. **DATE COMPLETED:** 5/31/2013 **PERSON(S) RESPONSIBLE:** AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent **W478** - A meal-time observation check list has been developed and the DDA1, HPAs, psychologists, AC Managers and shift charges have been directed to complete at least one per week at various meals for the houses to which they are assigned. **DATE COMPLETED:** 5/31/2013 **PERSON(S) RESPONSIBLE:** AC Managers HPAs Psychologists Muhammad Thompson, DDA1 Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent	

Brad Benoit 5/29/13

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

May 17, 2012
CERTIFIED MAIL (7007 1490 0003 4205 8286)

Dr. Asha Singh, Superintendent
Fircrest School PAT A
15230 - 15th Avenue NE
Shoreline, WA 98155

RE: Annual Recertification Survey
4/30/2012 and 5/3/2012

Dear Dr. Singh:

From 4/30/2012 through 5/3/2012 ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

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W 000	INITIAL COMMENTS This report is a result of the annual recertification survey conducted at Fircrest School between 4/30/12 and 5/3/12. The survey was conducted by: Kathy Heinz Janette Buchanan Terry Patton Mark White Paul Rowe (Federal Contract Surveyor) The surveyors are from: Residential Care Services ICF/ID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 and	W 000	RECEIVED DSHS/ADSA JUN 08 2012 Residential Care Services Certified Residential Programs	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to insure the main kitchen was handling food properly. Failure to handle food properly puts Resident ' s at risk of food borne illness. Observations in the morning on 5/1/12 of the facility ' s main kitchen , revealed staff #1 had pulled three large turkeys, fish, beef , and purred items from a freezer and placed it into the refrigerator. Staff #1 did not date the pulled food. The kitchen manager was unable to tell the state	W 104	W104 Fircrest will ensure food is handled properly as to keep residents safe from food borne illnesses through: • The development and implementation of a procedure outlining the use of tags to specify date the product was pulled from the freezer and the planned use date. All Dietary staff will be trained on the procedure. The Cook 3 will monitor the use of tags on products pulled by	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashan Smyth — TITLE: SUPERINTENDENT — (X6) DATE: 6/6/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G053	A. BUILDING _____ B. WING _____	05/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 surveyors when the food had been pulled out of the freezer and placed into the refrigerator. The kitchen manager stated the staff assigned to pull the food did not work on the weekends so she thought the food might have been pulled on Friday or Monday. The head cook, touched the food with his finger to determine how defrosted the food was. The kitchen manager asked the head cook to cook the turkeys and dispose of the beef immediately following surveyor inspection. Observation of another refrigerator revealed a baking pan full of a thick liquid. There were three cartons sitting in the liquid. One carton had a hole in the side. The cartons were not dated. The kitchen manger stated the cartons were full of egg whites and upon survey inspection she asked staff #1 to throw away the cartons of egg whites. Observation of the "warehouse " area of the kitchen revealed there was a box of very ripe and moldy bananas. There were large boxes of pasta that had been opened and not resealed. Upon inspection the kitchen manger asked staff #1 to dispose of the pasta. Observation on 5/1/12 at 3:15 pm in the main kitchen revealed staff had pre-dished fish and tater tots into containers and then placed the containers into insulated trays. Upon survey inspection , the kitchen manager measured the internal temperature of the fish. The internal temperature was 111 degrees. The internal temperature should have been 140 degrees. The fish and tater tots were reheated by kitchen staff to a safe temperature prior to being delivered to the Residents.	W 104	performing weekly checks and providing written documentation to the Food Services Manager. • Dietary staff will be retrained on the current guidelines on the closing and storage of all open food items. The Food Services Manager will monitor by conducting a weekly walk through the warehouse to ensure foods are stored properly. • Dietary staff will be retrained on the proper loading times for all meals. New signs specifying loading times will be also be posted. The Cook 3 will ensure food is loaded at the correct time and will monitor food for correct temperature as warranted. Person Responsible: Food Services Manager and Assistant Superintendent Completion Date: June 17, 2012.	

Keough
6/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	Continued From page 2 Staff placed a green salad for a resident 's evening meal into a thermal container. Staff did not put Ice in the container to keep the salad cold. Upon request by the state surveyors, the kitchen manager took an internal temperature of the salad. The temperature was about 55 degrees and should have been held at 45 degrees. The salad was thrown away. The kitchen manager stated the kitchen staff should not have dished the fish and tater tots for the evening meal until 4:30 pm.	W 104		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by:. Based on observations, interviews and record reviews it was determined the facility failed to proved 3 of 13 sample Residents (#5, #8, #11) the opportunity to make choices of what to eat during two dinner meals and two lunch meals. Failure to provide the opportunity to make choices of what to eat resulted in individuals not being allowed to exercise choice and self-management during meals. Findings include: Observations of sample Resident #5 on 4/30/12 during lunch at her house revealed the only food offered was fish nuggets, salad and noodle soup. Staff called Resident #5 up to the cart and asked her if she wanted the fish nuggets and salad. Staff did not offer or present alternatives to what was being served. On 5/1/12 during lunch at the Adult Training room Resident #5 ' s lunch came to	W 247	**W247** Fircrest will ensure clients are afforded opportunities for choice and self-management by: • Unit and ATP staff will be retrained on the implementation of Resident #5's Choice Making Assessment. AC3 and AC Manager will ensure choices are ordered from Dietary Department and available for client meal times. • Unit staff will be retrained on the implementation of Resident #11's Choice Making Assessment, including the facility's expectation that staff will provide encouragement of additional foods when a limited amount is consumed at meal time.	

Hough
6/6/12

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W 247	Continued From page 3 her on a thermal tray. The tray contained a sandwich, carrots, jello, corn and a small carton of milk. Staff did not ask her if she wanted what was being served or if she would prefer something different. Review on 5/4/12 of Resident #5 ' s Choice Making /Assessment fated 5/20/12 revealed she makes choices by reaching and taking items from a " buffet of several choices " . Interview with the Attendant Counselor Manager (ACM) on 5/4/12 confirmed that choices were not available. Observation of sample Resident # 11 on 4/30/12 during dinner revealed the only food offered was a sandwich " wrap " salad and chicken noodle soup. Staff asked Resident #11 if she wanted soup. Resident #11 shook her head " yes " and only ate the chicken noodle soup. Staff did not offer or encourage her to make alternate choices of what to eat, as she did not indicate she wanted the sandwich " wrap " or salad. Observation of the refrigerator and cupboards revealed there were numerous items that Resident #11 could have chosen from. Observation of sample Resident #8 on 5/1/12 during dinner revealed the he was given fish nuggets, French fries, carrots, salad and pudding. No alternative food items were out where he could see them and staff did not offer him alternate food choices. There were four frozen dinners in the freezer, but staff did not point this out to Resident #8. Review on 5/4/12 of Resident #8 ' s Choice Making Assessment dated 5/3/11 revealed that he will chose from a variety of items. Interview with direct care staff on 5/1/12 revealed he did not offer a choice because he knew Resident #8 likes fish nuggets.	W 247	• Unit staff will be retrained on the implementation of Resident #8's Choice Making Assessment, including the facility's expectation of staff being aware of choices available on the unit and offering the choices respectively. Additionally, all unit staff will be retrained on the facility's expectation to follow *Unit Meal Guidelines*. Person(s) Responsible: Attendant Counselor Managers of 301-302, 303-304 and 305-306, and the Intermediate Care Facility (ICF) Director Completion Date: June 17, 2012 Revision 06-05-2012	

Straight
6/6/12

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Arbuckle
6/6/12

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

December 2, 2011
CERTIFIED MAIL (7007 1490 0003 4205 8330)

Dr. Asha Singh, Superintendent
Fircrest School PAT A
15230 - 15th Avenue NE
Shoreline, WA 98155

RE: Post Survey 11/16/2011 through 11/18/2011 to the Recertification Survey 5/12/2011 through 5/20/2011

Dear Dr. Singh:

From 11/16/2011 through 11/18/2011, ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the post survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing.. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review); and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

DEPARTMENT OF HEALTH AND [illegible]MAN SERVICES
CENTERS FOR MEDICARE & MED[illegible]AID SERVICES

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W 000	INITIAL COMMENTS This Statement of Defecincies is based on a recertification survey completed by Kathy Heinz, Gerald Heilinger, Terry Patton and Mark White between 5/12/11 and 5/20/11.	W 000		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, it was determined that Resident #13 was not afforded privacy while sitting on a toilet for 25 minutes with the bathroom door open. A male State Agency Surveyor observed her sitting on the toilet. Failure to provide privacy subjected the Resident to embarrassment. Findings include: Observation on 5/18/11 of Resident #13 at House [redacted] between 07:25 and 07:50 revealed she sat on a toilet with her pants down and the door to the bathroom open. The bathroom door opened into a hallway that led to Residents' bedrooms and the medication dispensing room. A privacy curtain at the opening of the hallway was not drawn shut. Residents, visitors, family members, and staff (including nurses) regularly use this hallway and would be able to easily see someone sitting on the toilet with the door open. The State Agency surveyor observed her when he walked down the hallway. On two occasions a direct care staff walked by the door without closing the door, going in to assist Resident #13, or taking any other measures which would insure Resident	W 130	**W 130 Protection of Clients Rights** Fircrest upholds that all individuals are to be treated with dignity and respect. Fircrest will provide client rights training related to privacy to all AC staff: At least weekly, observations on the clients' homes will be completed by Duty Office RSCs to assure that clients' privacy is maintained. Results of these observations will be given to AC Managers and PAT Director for follow up. Person Responsible: AC Managers and PAT Director Completion Date: August 1, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] Director PAT A 7/18/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that [illegible] safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days [illegible] the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 [illegible]owing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued [illegible]gram participation.

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W 130	Continued From page 1 #13 could not be observed sitting on the toilet by other people in the house.	W 130		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to report six incidents in which it was alleged either abuse, neglect or mistreatment occurred. The facility was aware of the allegations and conducted an internal investigation, but did not report the incidents to the Complaint Resolution Unit (CRU) as mandated reporters. Subsequently, the facility is investigating incidents to determine if the allegation is valid prior to filing a mandatory report. Failure of the facility to report incidents to the State Agency prevents the State Agency from having immediate knowledge of incidents for investigation. Findings include: 1. Review on 5/12/11 of an Event Report dated 4/18/11 revealed that Resident #1 told two staff that he had touched a peer in a sexual manner while they were in the bathroom together. This incident in which it was alleged inappropriate sexual activity occurred was not reported to the State Agency. 2. Review on 5/16/11 of an Event Report dated 11/14/10 revealed Resident #1 was eating a snack when he made the statement to staff that	W 153	**W 153 Staff Treatment of Clients** As RCW 74.34 has been interpreted by Residential Care Services in its April 28th Clarification letter to include the reporting of all allegations of abuse, neglect, financial exploitation and abandonment to the DSHS Complaint Resolution Unit (CRU), Fircrest will report all allegations of the aforementioned mistreatment to the CRU through the DDD IR electronic reporting system. In the event that reporting via the electronic system is not possible, a phone report will be made to the CRU. When the CRU phone messaging system is full, a report will be made as soon as the system is able to receive messages. This action was implemented on July 8th, 2011. A monthly review of incidents and events by both the PAT A Director and the Director of Quality Assurance will occur to assure the reporting of all allegations of abuse, neglect, financial exploitation and abandonment occur. If one allegation is found to have not been reported to the CRU, it will be reported via the DDD IR electronic reporting system immediately. Implementation date: July 8, 2011 Person Responsible: PAT A Director and Director of Quality Assurance	

7/18/2011

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W 153	Continued From page 2 staff #1 needed to apologize because staff #1 had " pushed him away. " Resident #1 then repeated the allegation when staff #1 entered the room. The allegation of potential staff mistreatment/abuse was not reported to the state agency. 3. Review on 5/16/11 of an Event Report dated 2/11/11 revealed staff #1 was watching TV with Resident #21 for whom he was providing 1:1 support. Staff #2 who was on his way to the dining room with a Resident, changed the channel on the TV. Staff #1 became angry at staff #2 because staff #1 changed the channel on the TV. Staff #1 got up from the couch and started following staff #2, leaving his 1:1. Staff #1 was " screaming and yelling " at staff #2. Staff #3 asked staff #1 to return to Resident #21 but he continued to yell at staff #2. The incident in which it was alleged staff neglected Residents was not reported to the State Agency. 4.Review on 5/12/11 of an Event Report dated 11/3/10 revealed Resident #15 was asleep. Staff #1 observed Staff #2 " pulling and jerking " on his shirt to get him out of a chair. After being told to stop by Staff #1, Staff #2 continued to pull and jerk on Resident #15 ' s shirt to get him out of the chair. Staff #1 reported this to the facility as abuse. The facility did not report this incident of alleged abuse to the State Agency. 5.Review on 5/17/11 of an Event Report dated 2/9/11 revealed Expanded Sample Resident #14 tipped over in her wheelchair while riding in a facility van. The facility investigation determined this occurred because staff did not properly strap the wheelchair into the van. The investigation also determined the staff had not been trained on how to properly strap Individuals into wheelchairs while in the van. The facility did not report this	W 153		

7/18/2011

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W 153	Continued From page 3 incident of alleged neglect to the State Agency. Interview with administrative staff on 5/16/11 verified the incidents 1-5 had not been reported to the State Agency. 6. Review on 5/12/11 of an Event Report dated 12/10/10 revealed that a Nurse responsible for completing a Urinalysis for Resident #16 did not assure the Urinalysis was completed. Subsequently, Resident #16 was admitted to a hospital and treated for 5 days for a severe Urinary Tract Infection. Interview on 5/19/11 with the Nurse Manager who investigated this incident revealed that the Nurse responsible for obtaining the urinalysis was aware the urinalysis was necessary but did not obtain it. The Nurse Manager confirmed she did not report this to the appropriate state agency.	W 153		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on observation, record reviews, and interviews, it was determined the facility failed to insure they protected Residents while they investigated an allegation of abuse against Staff #3. The facility did not insure Staff #3 had unsupervised contact with Residents. Staff #3 was not supervised when he went from a room near the Duty Office to and from the kitchen where he was assigned to work while the facility was doing their investigation of the allegation. Also the facility could not insure that Staff #3 did not leave the room where he was told to report at	W 155	**W 155 Staff Treatment of Clients** All staff reassigned for allegations of client abuse or neglect now report directly to their reassignment work location and remain there for the duration of their shift. The reassignment area supervised by the Duty Office underwent environmental changes to ensure supervision of staff reassigned to that area.	

7/18/2011

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W 155	Continued From page 4 the beginning of his shift. Failure to insure that Staff, who have been alleged to have abused Residents, are supervised at all times prevents the facility from insuring that Residents are safe. Findings include: Review on 4/12/11 and 5/12/11 of a Facility Investigation of an incident dated 4/1/11 revealed Staff #3 was alleged to have abused Resident # 17 during a restraint. The facility assigned Staff #3 to duties not involving the care of vulnerable Residents by having him work in the facility ' s kitchen. At the start of each shift Staff #3 spent time in a room adjacent to the Duty Office prior to going to his alternate work assignment at the kitchen. The Duty Officer was to insure that Staff #3 did not have contact with Residents while in this room. Observations of the room on 4/12/11 and 5/12/11 revealed the Duty Officer staff could not see into the room from their desk. Also, the room had a back door which allowed access out of the room to an area where Residents frequently go. Interview with a Duty Officer on 5/12/11 revealed staff were not monitored on their way to or from their alternate work assignments on campus, allowing them free access to Residents on campus. Staff #3 had to go through areas on campus where Residents lived and moved about the campus to get to the kitchen where he was assigned to work under the constant observation and supervision.	W 155	The changes include: 1.) Area now only has one egress located next to the Duty Office, 2.) Duty Office solid door was replaced with glass panel door for increased visibility of reassigned staff, 3.) Duty Office desk was reconfigured for line of sight of reassignment room egress. Person Responsible: PAT Director and QA Director Completion Date: June 3, 2011	
W 269	483.450(a)(1)(ii) CONDUCT TOWARD CLIENT These policies and procedures must address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible.	W 269	**W 269 Conduct Toward Client** Fircrest will develop a Standard Operating Procedure to address the extent to which choice will be accommodated in daily decision making, emphasizing self-determination and self-management to the extent possible.	

7/18/2011

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W 269	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews it was determined the facility failed to consistently promote independence during meals. Facility staff did not encourage Residents to choose what to eat or encourage them to pour their own liquids, cut up their food or serve themselves for 3 of 11 sample Residents (#5, #10, #11). Failure of staff to actively promote decision making, self management and choices during meals, prevents Residents the opportunity to become as independent as possible. Findings include: 1.Observation of Resident #10 on 5/16/11 during lunch at the Adult Training Program (ATP) revealed she ate the meal that was packed in a lunch bag and did not offer her any choices. During the meal Resident #10 showed she was capable of opening a small carton of milk and pouring it into a glass. However, staff did not encourage her to be more independent during the bulk of the meal when they opened a baggie containing a sandwich, cut it up for her and poured water into a glass without encouraging her or allowing her to do it for herself. 2.Observation of Resident #10 on 5/17/11 during dinner, at House 301 revealed staff did not encourage her to make a choice of what to eat. Staff took the food from the tray, put it onto a plate for her and cut up her sandwich. Interview with staff on 5/17/11 revealed Resident #10 will not eat food she does not like which is the way she indicates choices. No choices of alternate food was offered. Review on 5/19/11 of Resident #10 's Choice	W 269	All staff will be trained on the new Standard Operating Procedure. All AC staff will be retrained on the choice making abilities of individuals they are supporting. Person Responsible: PAT Director Completion Date: August 1, 2011	

7/18/2011

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W 269	Continued From page 6 Making Assessment verified she is capable of making choices " from an array of food at a buffet ". Review on 5/19/11 of Resident #10 ' s Individual Habilitation Plan (IHP) dated 10/6/10 revealed she " is learning to make choices as to the type of food she wants, condiments, drinks etc. " There was no documentation in Resident #10 ' s IHP indicating she needed staff to cut up her food, serve her food or pour her drink. 3. Observation of Resident #11 on 5/17/11 during lunch at ATP revealed staff did not encourage Resident #11 to choose what he wanted to eat. The staff did not encourage Resident #11 to serve himself. Rather, staff took food from a tray that had been prepared in the main kitchen and placed it on a plate. Staff then gave the plate to Resident #11. Staff then cut up Resident #11 ' s burrito without encouraging him to cut it himself. Review on 5/19/11 of Resident #11 ' s Choice Making Assessment dated 6/17/09 revealed he " needs to have choices presented with gestural cues and needs to see choices ". Interview with staff on 4/17/11 revealed Resident #11 is only offered alternative food if he demonstrated he does not want what is being served. 4. Observation of Resident #5 on 5/17/11 at lunch, revealed staff gave her food that had been prepared by the main kitchen. Staff did not encourage her independence by indicating she could have something else if she wanted. Staff then cut her food up without ask her if she wanted them to do it or assist her to cut the food herself. Review on 5/19/11 of Individual #5 ' s IHP dated 12/1/10 revealed staff should assist as needed to cut up her food. The IHP also says staff should encourage her to make meal time	W 269		

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W 269	Continued From page 7 choices. No alternate food was offered.	W 269		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews and interview, it was determined that for 25 days the Nurse who was Resident #16 ' s Health Care Coordinator (HCC) did not obtain a physician directed urinalysis. On the 26th day Resident #16 was hospitalized for a severe urinary tract infection. The facility had no system to assure Resident #16 received necessary preventative cares, in this case a urinalysis, when the HCC failed to provide that preventative care. The facility ' s failure to assure a system for providing preventative care resulted in Resident #16 being hospitalized for 5 days due to a severe urinary tract infection and prostratitis. Findings include: Review on 5/12/11 of an Event Report revealed that on 12/7/10 Resident #16 was found by staff " drooling and pale. " Resident #16 was hospitalized. Further review revealed that on 11/5/10 a Physician directed that Resident #16 have a urinalysis to determine if he still had a urinary tract infection following antibiotic treatment. The Nurse responsible did not assure the urinalysis was completed. Subsequently, Resident #16 was admitted to a hospital for intravenous antibiotic treatment of prostratitis and a severe urinary tract infection from [redacted]10 to [redacted]10. Interview on 5/19/11 with the Nurse Manager who investigated this incident revealed	W 322	**W 322 Physician Services** Nurses will be retrained on the Fircrest's Nursing Protocols and Procedure for urinary tract infection. This retraining will include: definitions, components/common cause, subjective and objective findings, nursing diagnosis, medical diagnosis, nursing interventions, criteria for prompt or immediate referral to medical provider by RN, criteria for consultation with the registered RN/LPN, documentation, and follow-up plan. Nurse will notify RN 4 of any individuals presenting or exhibiting acute abnormal health signs or symptoms immediately. RN 4 will monitor for proper assessment, treatment and/or referral to medical provider in accordance with Fircrest's Nursing Protocols and Procedures. Person Responsible: PAT RN 4 and PAT Director Completion Date: August 1, 2011	

AB 7/18/20

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W 322	Continued From page 8 that the Nurse responsible for obtaining the urinalysis was aware the urinalysis was necessary but did not obtain it. There is no system in place to assure that physician directed testing is completed.	W 322		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility did not insure that Quarterly Nursing Physical Examinations were completed and current with 4 of 11 Sample Residents (#4, #7, #9, and #12) and Expanded Sample Residents #14, #18, #19, and #20. The facility did not have a method for tracking the completion of Quarterly Nursing Physical Examinations. Subsequently, when nurses did not do the Quarterly Nursing Physical Examinations, the facility was unaware they were not being done. Failure to have a system to insure Quarterly Nursing Physical Examinations are completed prevents the facility from insuring that Residents ' health problems are recognized and treated in a timely manner. Findings include: 1. Review on 5/19/11 of Resident #12 ' s habilitation record revealed the most recent Quarterly Nursing Physical Examination was dated 6/16/10. Three Examinations were missing. Interview on 5/19/11 with the Nurse Manager verified this was the most recent examination.	W 336	**W 336 Nursing Services** A master calendar of Quarterly Nursing Physical Exams will be synchronized with 90 day medication reviews for continuity of care. Each HCC will document date completed on a master tracking spreadsheet. Monthly audits will be conducted for completion. Person Responsible: PAT RN 4 and PAT Director Start Date: Synchronization will begin in July; first audit will be completed in August 2011.	

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W 336	Continued From page 9 2. Review on 5/19/11 of Resident #7 ' s habilitation record revealed the most recent Quarterly Nursing Physical Examination was dated 6/27/10. Three Examinations were missing. Interview on 5/19/11 with the Nurse Manager verified this was the most recent examination. 3.Review on 5/18/11 of the habilitation record for Resident #9 revealed her last Quarterly Physical Examination by a Registered Nurse documented in the habilitation record was dated 11/10/10. One Examination was missing. 4.Review on 5/18/11 of the habilitation record for Resident #14 revealed her last Quarterly Physical Examination by a Registered Nurse documented in the habilitation record was dated 6/14/10. Three Examinations were missing. 5.Review on 5/18/11 of the habilitation record for Resident #18 revealed his last Quarterly Physical Examination by a Registered Nurse documented in the habilitation record was dated 6/17/10. Three Examinations were missing. 6.Review on 5/18/11 of the habilitation record for Resident #19 revealed her last Quarterly Physical Examination by a Registered Nurse documented in the habilitation record was dated 7/28/10. Two Examinations were missing. 7.Review on 5/18/11 of the habilitation record for Resident #20 revealed her last Quarterly Physical Examination by a Registered Nurse documented in the habilitation record was dated 6/6/10. Three Examinations were missing. Interview on 5/19/11 with the Nurse Manager	W 336		

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W 336	Continued From page 10 verified that there is a problem with the system for Registered Nurses to complete the Quarterly Physical Examinations.	W 336		

7/18/2011

Aging & Disability Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23
April 30, 2010

By Facsimile

Dr. Asha Singh, Superintendent
Fircrest School Pat A
15230 15th Northeast D
Seattle, WA 98155

RE: Recertification Survey 04/13/2010-04/21/2010

Dear Dr. Singh:

Included with this letter you will find the draft CMS 2567 Statement of Deficiencies (SoD) which resulted from a recertification survey completed on 04/21/2010.

Please be advised of your right to review this draft survey and submit any additional information to clarify or dispute the survey team's findings. Your response should be faxed to the ICF/MR Quality Assurance office and arrive no later than two working days after the date the draft was faxed to your facility.

In the event that there is not a dispute with the survey findings, or once any disagreements pertaining to the survey report have been resolved, the SoD will be considered final and the Plan of Correction (PoC) will be due within ten calendar days of receipt of the final SoD.

In order to meet the ten day timeline, you may write the PoC onto the faxed copy of the SoD for review by the ICF/MR survey team and fax it back to this office, signed and dated, to:

Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

After review of the PoC by the ICF/MR team, the original SoD will then be mailed to your facility in order to add the acceptable PoC. A copy of the guidelines for an acceptable PoC is included with this fax.

Thank you for your attention to this matter.

Sincerely,

Tom Farrow, Field Manager
ICF/MR Survey and Certification Program

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W 000	INITIAL COMMENTS This report is a result of the Annual Recertification Survey conducted at Fircrest School from 4/13/10 through 4/21/10 completed by #19986, #21833, #12564, and #12891, and #29174 from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809	W 000	**W104 Governing Body.** The "vending machine account" to which this statement of deficiencies is referring is actually money taken from the Fircrest General Welfare account. The money is not removed from the individual's account until the Unit Petty Cash Log is returned to the Fiscal department with an accounting of the amount each individual spent. Therefore, it was not necessary for the reader of the Petty Cash Log to know how much the Resident has available to them. However, Fircrest will revise the guidelines for "Maintaining and Accounting for Client Cash on Hand" to include revisions to the Client Personal Spending Ledger so that it will indicate the starting amount of petty cash kept on the house for each individual. A column for the subtraction of each disbursement will be added so a running total of money available is listed. Revisions will also be made to the process involved in accounting for funds (other than funds specifically designated for vending machines) when there is no receipt present. The Client Cash Withdrawal form must be approved by the PAT Director or designee when there is no receipt to account for money withdrawn from an individual's account. An unannounced audit of all homes maintaining petty cash funds will occur	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on records review and interview verification, it was determined the facility failed to provide oversight of funds for Residents of house 311/312. Vending Machine Program funds and funds used for community outings were obtained by staff and were used without a full and accurate accounting of the funds. Findings include: 1. Observation on 4/14/10 at house 311/312 in the afternoon, revealed staff #1 came into the	W 104		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alicia Smith — TITLE: Superintendent — (X6) DATE: 7/15/10

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ... safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ... the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ... following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ... program participation.

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W 104	Continued From page 1 room and handed staff #2 two quarters. Staff #1 told Staff #2 it was the remaining money of the "vending machine program." Staff #2 took the quarters. Observation of the ledger on 4/15/10, in which the monies for the vending machine program were tracked, revealed there was no way to verify how much money Residents had in their "vending machine account." Interview with Administrative staff on 4/15/10 verified the accounting process used to track the money spent in the "vending machine program" did not allow the reader to determine how much money Residents had available to them. 2. Review on 4/14/10 of the following "cash withdrawal" slips revealed the following: · $45.00 was withdrawn on 3/21/10 for three residents to go on an outing. Staff reported each resident spent 15.00 dollars at a fast food restaurant having dinner and a snack. There were no receipts provided to the facility after the outing. · $45.00 was withdrawn on 3/5/10 for 9 residents to go on an outing. Staff reported each resident spent 5.00 dollars on a "burger, shake and fries." No receipts were provided to the facility. · $84.00 was withdrawn on 3/18/10 for seven residents to go to a movie. Receipts were not provided for all Individuals. · $30.00 was withdrawn on 3/11/10 for an "outing" for 6 Residents. Receipts were not provided for all Residents who went on the outing. Interview on 4/14/10 with Administrative staff verified there were no receipts.	W 104	on a quarterly basis by the Fiscal Department. Results of these audits will be given to the PAT Director. Target Completion Date: 6/30/2010 Person Responsible: Assistant Superintendent and PAT A Director	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS	W 125		

7/15/10

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 125	Continued From page 2 The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to afford 111 Residents (12 of 12 sample Residents [#1 through #12] and 99 non-sample Residents) due process prior to approving restrictive procedures. The facility developed and implemented a variety of restrictive measures including sedation, physical restraints, mechanical restraints, restrictive diets, protective supports, room monitors and restricted access to funds without insuring Residents' rights were protected. Finding includes: Review on 4/16/10 of Resident #11's record revealed an "Informed Consent for Medical Care" form dated 12/31/09 which showed the Human Rights Committee (HRC) had approved the use of physical restraint for holding him on the examination table, blood draws and routine hygiene, such as cutting nails. The consent also included approval for sedation for some medical procedures, examinations and treatments and the use of a mechanical restraint, such as a "papoose board". Review on 4/16/10 of the "Consent and HRC Approval for Restrictive Procedures in 2010" form revealed 111 Residents (Sample Residents #1 through #12, and 99 non-sample Residents) had restrictive procedures that were approved on 4/8/10 by the HRC. There was no evidence to suggest the	W 125	**W125 Protection of Clients Rights** During the time of each individual's IHP all informed consents will be reviewed by the Human Rights Committee (HRC). Supporting information as to why the restriction is necessary will be presented to the HRC in writing and by a member of the Interdisciplinary Team. The Quality Improvement Department will keep a log of consents approved by the HRC for each individual. This log will be reviewed by the PAT A DDA 1 and the Director of Quality Improvement on a spot check basis. Target Completion Date: 6/30/10 and ongoing Person Responsible: PAT A DDA 1 and Director of Quality Improvement	

7/15/10

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W 125	Continued From page 3 facility provided the HRC with supporting information which would indicate why the facility thought the restrictions were necessary. Interview with administrative staff on 4/20/10 verified the facility did not insure the HRC had documentation explaining why the restrictive procedures were necessary.	W 125		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to insure that 3 of 12 Sample Residents (#9, #11, and #12) had interventions designed to help them use their time constructively. Residents #9, #11, and #12 were observed engaging in repetitive activities for long periods of time. Findings include: 1. Observations of Sample Resident #9 on 4/14/10 from 10:36 am to 10:47 am and from 3:00 pm to 3:21 pm; and on 4/15/10 from 9:37 am to 9:59 am revealed he spent these times sitting or lying down on a couch chewing on or mouthing items (a flexible orange plastic tube about 1" in diameter, a ball made out of plastic coated wire with small objects on the wires, towels). Review on 4/16/10 and 4/19/10 of Resident #9 's Habilitation Plan revealed he had no intervention to learn to use his time in a meaningful manner. Interview on 4/19/10 with a facility administrator verified there was no intervention for Resident #9	W 227	**W227 Individual Program Plan** Sample individuals #9, 11 and 12 as well as all the individuals in PAT A will be assessed as to their ability to use their unstructured time (non–work/school, meal, personal hygiene times) in an adaptive and socially acceptable manner. For those individuals assessed as having a prioritized need in this area, a strategy will be developed to address this need. The information on this strategy will be communicated to the staff directly responsible for implementation. Engagement in activities during unstructured times will be monitored by IDT review of direct care staff documentation, and IDT direct observation and discussion. IDT reviews will be documented in the QMRP notes. PAT A DDA 1 will conduct a quarterly spot check to ensure completion. Target completion date: 6/30/2010 Person Responsible: PAT A DDA 1 and PAT A Director	

A Smith
7/15/10

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 227	Continued From page 4 to learn to use his time in a meaningful manner. 2. Observations of Sample Resident #12 on 4/14/10 from 10:01 am to 10:26 am, from 12:04 pm to 12:31 pm, and from 3:31 pm to 3:42 pm; and on 4/15/10 from 10:06 am to 10:26 am and from 3:13 pm to 3:24 pm revealed she spent the majority of this time sitting with her hands near her ears/face, body rocking, head rocking, and often closing her eyes. Review on 4/19/10 of Resident #12's Habilitation Plan revealed she had no intervention to help her use her time constructively. Interview on 4/19/10 with a facility administrator verified there was no intervention to teach her to use her time constructively. 3. Observation Sample Resident #11 on 4/14/10 at house 303 from 3:15 until 3:50 and from 4:10 until 5:11 and 4/15/10 from 8:30 am until 9:10am and from 3:30pm until 4:49pm revealed he sat in the same chair and randomly dropped round plastic colored discs into a thin plastic square shaped object (Connect Four). On occasion, he would stop dropping the discs and would rock forward and backward while seated in his chair. Review on 4/19/10 of Resident #11's Individual Habilitation Plan revealed "interacting with Connect Four is his favorite activity". Interview with direct care staff on 4/14/10 revealed Resident #11 has a routine and does not deviate. Interview on 4/19/10 with Administrative Staff verified Resident #11 needs to learn to participate in other activities.	W 227		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed	W 249		

7/15/10

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview verification, it was determined the facility failed to insure staff implemented programs for 2 of 12 Sample Residents (#9 and #12). Resident #9 had a program to address Pica (eating inedible objects). Sample Resident #12 had a program for requesting coffee and a program for not eating too fast. Staff did not implement these programs according to the Implementation Plans written by the facility. Findings include: 1. Review on 4/16/10 of Sample Resident #9's Individual Habilitation Plan dated 5/14/09 revealed he had an Implementation Plan to address Pica (eating inedible things) which directed staff to implement, in part, to "interact often" with him and try to get him "engaged in activities" or to look out windows as prevention strategies. Resident #9 was observed on 4/14/10 from 10:36 am to 10:47 am sitting on a couch (which was not near a window) chewing on an orange, plastic flexible tube. Staff tried to take the tube away from him but did not offer him an alternate activity. No other staff interaction occurred. Resident #9 was observed on 4/14/10 from 3:00 pm to 3:21 pm sitting/lying on a vibrating "bed" chewing on a flexible plastic tube. Staff did not attempt to engage him in any other activity. The "bed" was not near a window. On 4/15/10 he was observed from 9:37 am to 9:59 am sitting in a chair. Initially he was chewing on a	W 249	**W249 Program Implementation** To assure staff implement programs contained in the Individual Habilitation Plans (IHP), the Program Observation Form used by PAT A will be revised to include a section on the direct observation of programs. Staff who use the form will observe direct support staff working with individuals and will note if the staff has implemented programs that should have been initiated during the time frame of the observation. Appropriate feedback will be given to the direct care staff upon completion of the observation period. Completed Program Observation Forms will be reviewed at IDT meetings with program progress documented in QMRP notes. PAT A DDA 1 will conduct a quarterly spot check to ensure completion. Target Completion date: 6/30/2010 Person Responsible: PAT A DDA 1 and PAT A Director	

7/15/10

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G053	A. BUILDING _____ B. WING _____	04/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 6 towel. The staff took the towel from him and gave him a ball made of plastic coated wires with objects on the wires which he started chewing/biting on. Staff did not attempt to engage him in any other activity, and the chair was not near a window. On 4/15/10 at 3:39 pm Resident #9 was sitting in a chair facing a window. Staff got him up and moved him to a different chair facing away from the window. At 3:47 pm after assisting him in the bathroom, staff took him to a couch that was away from windows and gave him the ball made of plastic coated wires which he started chewing/biting on. Interview on 4/19/10 with a facility administrator verified the staff were not correctly following the plan to address Pica. 2. Review on 4/19/10 of Sample Resident #12's Habilitation Plan revealed she had a program to request a cup of coffee by using the sign for coffee after verbal prompting by staff. On 4/14/10 at the Senior Program at approximately 10:10 am staff gave her a mug of coffee. On 4/14/10 at house 315/316 at approximately 3:45 pm staff took her into the dining room and asked her if she wanted coffee. On 4/15/10 at the Senior Program at approximately 10:15 am staff gave her a mug of coffee. On 4/15/10 at house 315/16 at approximately 3:25 pm she was taken into the dining room and given a cup of coffee. On none of these occasions was she asked to manually sign for her coffee. Interview on 4/19/10 of a facility administrator verified staff should have implemented the program and verbally prompted her to sign " coffee ". 3. Review on 4/19/10 of Sample Resident #12's Individual Habilitation Plan dated 11/19/09	W 249		

7/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G053	A. BUILDING _____ B. WING _____	04/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRCREST SCHOOL PAT A	15230 15TH NORTHEAST D SEATTLE, WA 98155

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W 249	Continued From page 7 revealed she had a program to not eat too fast. The Implementation Plan indicated staff were to verbally cue her to slow down and give her time to respond to the cue. Observations of Resident #12 on 4/14/10 at the noon meal and the evening meal revealed staff gave her a verbal cue to slow down but then immediately put their hand on her hand. Interview on 4/19/10 of a facility administrator verified staff should have implemented the program as written by verbally cuing her to slow down, waiting for her to respond, and then providing physical assistance if necessary.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility's Human Rights Committee approved restrictive procedures for 111 Residents (12 of 12 sample Residents [#1 through#12] and 99 non-sample Residents) for medical, dental, dietary, protective supports, room monitors and restricted access to personal money without reviewing any other supportive information provided by the facility about why the facility was considering the need for the restrictive procedures. They also failed to consider whether less intrusive methods had been tried, a risk/benefit analysis or if there was a comprehensive program addressing the particular behavior for which the restrictive procedure was	W 262	**W262 Program Monitoring and Change** During the time of each individual's IHP all informed consents will be reviewed by the Human Rights committee (HRC). Supporting information as to why the restriction is necessary will be presented to the HRC in writing and by a member of the Interdisciplinary Team. The Quality Improvement Department will keep a log of consents approved by the HRC for each individual. This log will be reviewed by the PAT A DDA 1 and the Director of Quality Improvement on a spot check basis. Target Completion Date: 6/30/10 and ongoing Person Responsible: PAT A DDA 1 and Director of Quality Improvement	

7/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 262	Continued From page 8 being used. Findings include: Review on 4/16/10 of Resident #11's record revealed an Informed Consent for Medical Care form dated 12/31/09 which showed the HRC had approved the use of physical restraint for holding him on the examination table, blood draws and routine hygiene, such as cutting nails. The consent also included approval for sedation for some medical procedures, examinations and treatments (did not specify which medical procedures, treatments or examinations required the procedure) and the use of a mechanical restraint, such as a "papoose board" (it was not clear if the approval included all mechanical restraints or just the "papoose board"). Review on 4/16/10 of the Consent and HRC Approval for Restrictive Procedures in 2010 form revealed 111 Residents' (12 sample Residents' and 99 non-sample Residents) restrictive procedures were approved on 4/8/10 by the HRC. There was no indication the HRC was given the following: · Individualized programs for the specific restrictive procedures within the Individual Habilitation Plan; · The Positive Behavior Support Programs (PBSP); · A risk/benefit analysis for each restrictive procedure; · LA review of less restrictive methods tried by the facility, what they were or their effectiveness. Interview with administrative staff on 4/21/10 verified the HRC was not provided with individualized programs for each procedure; an analysis of whether the restrictive procedures were needed; IHPs, PBSPs or a risk/benefit analysis for each Resident who had a restrictive procedure for medical dental, dietary, protective supports, room alarms or restricted access to	W 262		

7/15/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 262	Continued From page 9 their funds.	W 262		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs; including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interview verification, it was determined the facility failed to administer drugs without error for 1 of 57 observed medication passes. Findings include: Observation on 4/24/10 at 4:10 PM revealed a nurse administered a Calcium Citrate, 200 mg tablet, to Expanded Sample Resident #13. Review on 4/19/10 of the Physician Orders for Expanded Sample Resident #13 revealed a Calcium Citrate 200 mg tablet is to be administered at 8:00 AM and 7:00 PM. Interview on 4/19/10 with the RN Manager verified the Calcium Citrate 200 mg tablet was not administered according to the Physician Orders.	W 369	**W369 Drug Administration** Fircrest will administer all medications according to physician orders. For individual # 13 the medication time was immediately corrected in accordance with the physician's order to give Calcium Citrate at 1200 and 2000. An event report was generated and the Nursing Supervisor completed the investigation. The nurse who administered the medication at the incorrect time was retrained on Nursing Procedure 1-F 6a, The Preparation and Administration of Medications. All PAT A nursing staff will be retrained on Fircrest Nursing Procedure 1-F 6a, The Preparation and Administration of Medications. All medication profiles for individuals in PAT A have been checked to ensure that all the medications are written to be administered according to the physician's orders. Medication Pass Observations will be used for follow-up to ensure compliance. On a quarterly basis or as needed, the lead LPN4 and the Nursing Supervisor will perform Medication Administration Observations for all the medication and treatments provided by nursing staff. The Nursing Supervisor will keep the records of the completed	
W 437	483.470(g)(3) SPACE AND EQUIPMENT The facility must provide adequate clean linen and dirty linen storage areas. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to keep laundry (bedding and face cloths) sanitary before they were used by Residents. Bed linens were stored on the floor at house 303/304. Clean laundry was delivered to the Adult Training Program (ATP) in bags that had been ripped or torn and then was dragged across	W 437		

7/15/10

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W 437	Continued From page 10 the floor by Residents. Contaminated laundry was not placed in leak proof bags prior to being sanitized. Findings include: 1. Observation at ATP (room in which Sample Resident #11 works) on 4/15/10 revealed a non-sample Resident dragging a laundry bag across the floor. The white bag was torn and contained clean laundry. In addition, contaminated laundry was thrown into a bag that was not leak proof. Review of the Facility's policy "Handling of Contaminated Laundry" revealed "all laundry shall be considered contaminated and shall be stored in containers designed to be leak proof". Interview with administrative staff on 4/15/10 verified the clean laundry should not be dragged across the floor in a torn bag, bags should be repaired and the contaminated laundry needed to be placed in leak proof bags. 2. Observation at ATP on 4/15/10 in room 88-E revealed a torn laundry bag was sitting on the floor. The bag contained clean laundry. Interview with Administrative Staff on 4/15/10 verified the clean laundry should not be sitting on the floor. 3. Observation at ATP on 4/15/10 in room 87-E revealed staff placed contaminated laundry in a bag resembling a fish net. Review of the Facility's policy "Handling of Contaminated Laundry" revealed "all laundry shall be considered contaminated and shall be stored in containers designed to be leak proof". Interview with Administrative Staff on 4/15/10 verified the contaminated laundry should be placed in a leak proof bag.	W 437	medication pass observations. Target Completion Date: 6/15/10 Person Responsible: PAT A Nursing Supervisor/RN4 **W437 Space and Equipment** Unit 303-304's improper storage of bed linens issue is resolved. All other PAT A units will be reviewed for proper storage of clean linens. ATP staff will be retrained on Fircrest's policy on the "Handling of Contaminated Laundry". Additional equipment will be purchased to provide for sufficient processing and handling of clean and contaminated laundry. Target Completion Date: 5/28/10 Person Responsible: ATP Supervisor and Assistant Superintendent	
W 440	483.470(i)(1) EVACUATION DRILLS	W 440		

7/15/10

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W 440	Continued From page 11 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct quarterly fire drills for each shift for four of nine house (303/304, 307/308, 311/312 & 315/316). The Annual Fire Drill Forms did not have the times of all of the fire drills which made it difficult to ascertain what shift the drill was held. Finding included Review on 4/14/10 of the facility Annual Fire Drill Records revealed house 303/304 had no documented fire drill for the night shift during the first quarter of the year 2010 or the second quarter of the year 2009. House 307/308 had no documented fire drills for the day shift during the second quarter of the year 2009 or the night shift during the fourth quarter of the year 2009. House 311/312 had no documented drills for the night shift during the first quarter of the year March 2010 or for the day shift during the second quarter of the year 2009. House 315/316 had no documented fire drills for the night shift during the first quarter of the year 2010 and no documented drill for the day shift during the fourth quarter of the year October 2009. Interview with administrative staff on 4/15/10 verified the facility did not hold quarterly fire drills for all houses.	W 440	**W440 Evacuation Drills** The Evacuation Drill Form had previously been redesigned to include the time of the drill, therefore making it easier to determine which work shift the drill was completed. The Safety Officer will contact the Attendant Counselor Manager of homes who have not completed the assigned fire drill by or before the 25th of each month so that the drill can be completed within the assigned month. The Safety Officer will assure that the drills are completed by the end of the month. Target Completion Date: 5/3/10 Person Responsible: Safety Officer and Director of Quality Improvement **W445 Evacuation Drills** All total evacuation drills will occur on each shift on a designated day each July. This will simulate a real emergency as all drills will occur at one time. The Safety Officer and Director of Quality Improvement will be present for the drills. The designated staff to complete the Evacuation Drill form will note any problems associated with the drill so that improvements can be made for the future. The Director of Quality Improvement will review all fire drills completed in the month of July to assure that a total evacuation drill has been held on each shift on each house. Target Completion Date: 5/3/10 Person Responsible: Safety Officer and Director of Quality Improvement	
W 445	483.470(i)(2)(i) EVACUATION DRILLS The facility must actually evacuate clients during at least one drill each year on each shift. This STANDARD is not met as evidenced by:	W 445		

7/15/10

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 445	Continued From page 12 Based on record review and interview verification, it was determined the facility failed to conduct fire drills which included an evacuation at least one time per year per house for four of nine houses (303/304, 307/308, 311/312 & 315/316). Finding includes: Review on 4/14/10 of the Annual Fire Drill Record for April 2009 through March 2010 revealed house 303/304 did not conduct an evacuation of the house during the "day shift". House 307/308 did not conduct an evacuation during the "night shift". House 311/312 did not evacuate for either the "day", "afternoon" or "night shift". House 315/316 did not evacuate during the "day shift" or the "night shift". Interview with administrative staff on 4/15/10 verified that evacuations for fire drills did not occur during the above mentioned shifts for each of the houses.	W 445		

7/15/10

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

- Lakeland Village SODs 2015 - 2010

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600, Olympia, WA 98504-5600

February 10, 2015

BY FACSIMILE and CERTIFIED MAIL (7007 1490 0003 4195 0840)

Important Notice – Please Read Carefully

Anthony DiBartolo, Superintendent
Lakeland Village
PO Box 200
Medical Lake, Washington 99022-0200

RE: Recertification Survey
1/12/2015 through 1/27/2015

Dear Mr. DiBartolo:

Residential Care Services (RCS) received your credible letter of allegation on February 9, 2015, from Lakeland Village, which alleges that substantial compliance has been achieved with the condition of participation (COP) for Client Protections (W122 – 42 CFR 483.420). RCS has found the allegation of compliance outlined in the letter to be credible. The survey and certification team will return to Lakeland Village to verify implementation of the plans outlined in the letter. Based upon information gathered during the visit, the state agency will determine if the facility has achieved substantial compliance with the COP.

Remedy
Substantial compliance with federal requirements or the immediate jeopardy must be achieved and verified by 2/19/2015 (23 calendar days from the date on which the survey was completed (SOM 3010)). Failure to achieve substantial compliance with 42 CFR 483.420 will result in termination from the Medicaid ICF/IID program (42 CFR 442.101 (3) (e); SOM 3005 E).

The department will proceed with termination until you have achieved substantial compliance with the client protections CoP. Compliance with the CoP must be verified on-site by RCS as substantially implemented by 2/19/2015. Compliance and verification of compliance by the ICF/IID team of all the deficiencies on the SoD must be achieved by the 90th calendar day, 4/27/2015.

An acceptable PoC must contain at a minimum the following core elements (SOM 3006.5):

- How the corrective action will be accomplished for the sample Individuals found to have been affected by the deficient practice;
- How the facility will identify other Individuals who have the potential to be affected by the same deficient practice, and how it will act to protect Individuals in similar situations;
- What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and
- When corrective action will be accomplished.
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your PoC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, Mail Stop: 45600
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

The Department will use the PoC and an onsite revisit as the basis for verifying correction of the deficiencies. If you modify your PoC after submission, you must immediately notify the above office in writing. Any PoC modification must address each "W"tag number with related details about any modifications.

Informal Dispute Resolution (IDR)
You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services

cc: CMS Regional Office, Washington State ICF/IID Team
Bill Moss, Assistant Secretary of ALTSA
Carl I. Walters II, Director of RCS
Donna Cobb, Senior Counsel
Evelyn Perez, Assistant Secretary of DDA
Donald Clintsman, Deputy Assistant Secretary of DDA
Janet Adams, DDA Office Chief
Larita Paulsen, DDA QM Unit Manager
Bruce Work, Medicaid Compliance Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	01/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of a recertification survey conducted at Lakeland Village between 1/12/15 through 1/27/15. The survey was conducted by: Gerald Heilinger, Kathy Heinz, Claudia Baetge, and Carla Lundberg The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-2405	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

...ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...g the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	01/27/201

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 100	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation of Active Treatment Services. Findings Include: The facility did not meet the Condition of Participation (COP) of Active Treatment Services. The facility did not ensure Residents received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports. Residents were observed spending significant blocks of time where no training program occurred. See W195.	W 100		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition Of Participation in Governing Body and Management by not exercising operating direction over the facility and by not meeting the requirements for the Conditions Of Participation of Active Treatment Services and Client Protections. This failure potentially affected all Residents served. Findings Include: 1. The governing body failed to exercise general operating direction in a manner which resulted in the facility not being able to ensure the facility was being maintained. See W104. 2. The facility did not meet the Condition of	W 102		

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W 102	Continued From page 2 Participation in Active Treatment Services by not assessing skills and training needs, by not developing training plans to address assessed needs, by not prioritizing training objectives, by not changing objectives when they had been achieved or were not making progress, and by restricting Residents ' rights without assessments and due cause. See W195. 3. The facility did not meet the Condition of Participation in Client Protections by not implementing a policy which resulted in the immediate reporting and thorough investigation of all allegations of abuse. The facility failed to develop and implement a system that provided for protection of Residents during the course of the investigation of abuse including the immediate removal of alleged perpetrators from contact with vulnerable Residents. The facility failed to develop and implement a system which assured guardians were notified of allegations of abuse involving their wards. The facility failed to develop and implement a system which reviewed internal investigations to assure the rights of Residents were protected and to identify and remedy policy violations. See W122 4. The facility failed to identify an allegation of physical abuse and to implement policy to protect Residents served. This resulted in the identification of an Immediate Jeopardy. See W127	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by:	W 104		

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W 104	Continued From page 3 Based on observations, record reviews and interview, Staff X failed to ensure that all facility maintenance was completed as needed, a procedure was developed to determine when repairs were completed, a staff training was completed, restraints were not used without an assessment and monitoring protocols, and to ensure all equipment used by Residents was clean. This failure placed Residents in the situation of living in homes in need of repair, having to use unsanitary equipment, and to be restrained without proper assessment and safeguards. Findings include: 1. Observation of Hillside Cottage on 1/12/15 at 3:30 PM revealed Resident #39 ' s dresser in his bedroom had a missing dresser drawer. Interview with Staff PP on 1/12/15 at 4:00 PM revealed Resident #39 had thrown his dresser over which broke the drawer in December 2014. Staff PP indicated a work order had been submitted to repair the broken drawer; however, one could not be located in the work order request system. Staff PP provided the State Surveyor with a facility wide list of 447 work orders which included all buildings on North and South campus, as of 01/12/15. Each work order identified the work order number, location and room, a description of the problem/needed repair and the requested date and completion date. Staff PP did not know the status of repairs as numerous work orders did not have the completion dates identified. Observation of Hillside Cottage on 1/15/15 at 5:00 PM revealed work order #14063000144 requested on 6/30/14 to repair hinges on kitchen cupboard had been completed but had not been recorded as completed; work order # 1411050072 requested on 11/5/14 to replace one of the missing bolts out of the overhead auto shutting	W 104		

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W 104	Continued From page 4 door hinge had been completed but not recorded as completed; work order # 14110300039 to replace a kitchen light had been submitted on 11/3/14 was completed but not recorded as completed; work order #14005090033 requested on 5/9/14 to fix three of the kitchen drawers that were sticking had not been completed; work order #14040700181 dated 4/7/14 to fix the broken door handle had not been completed. Interview on Sunrise Cottage on 1/21/15 at 1:30 PM with Staff TT acknowledged work orders have been a problem and stated " we don ' t know where they go and they never mark it when it ' s done ". In an interview on 1/21/15 at 9:30 AM with Staff WW, he described the facility's work order request system. He stated all work orders are entered into the Advanced Maintenance Management System (AMMS). Each work order is assigned a work order number by Central Management Office (CMO) and is submitted to Consolidated Support Services (CSS) for assignment and corrective action. CSS assigns the priority and response times for completion. All work order requests are recorded as: normal, urgent, critical. Staff WW acknowledged the facility is not allowed to make any repairs as all work is completed by CSS. Repairs that are considered urgent are called in only by authorized staff: the Facility Services Staff X or the PBX Operator. Staff WW indicated all call in work requests to CSS are to be completed within 24 to 48 hours. Record review of Facility Work Order Call Log made for December 2014 and January 2015 to CSS included the date, time, location and requested repair but did not identify the repair date and time. When asked the status of the urgent repair requests, Staff WW acknowledged	W 104		

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W 104	Continued From page 5 he assumed the work had been completed if he did not receive a call from the house where the work was requested from. Staff WW reported he would have to go to each unit to verify the work had been completed. 2. Observation of Hillside Cottage on 01/12/15 at 3:30 PM revealed a shower chair in the bathroom with a pubic hair on the seat. Interview with Staff PP stated the shower chair is used by Residents #40, #41, and #42. Staff PP acknowledged that facility staff were expected to disinfect the shower chair after each use. He confirmed there was no form to document cleaning schedule to ensure this occurred following each resident ' s use of the shower chair. 3. Record review of adaptive equipment used on Hillside Cottage revealed Resident #22 will be provided with a toilet-positioning belt when using the toilet to decrease risk of injury due to falls due to poor coordination and seizures. Observation of Hillside on 1/19/15 at 2:45 PM revealed the toilet positioning belt used for Resident #22 was stained and soiled. Interview with Staff XX revealed the toilet positioning belt is used when assisting Resident #22 with toileting. She confirmed there was no cleaning/disinfection system for the toilet positioning belt. 4. Observation on 1/20/15 at 70 Evergreen Cottage revealed there was a toilet with a seat back made from a piece of plywood which had been covered with vinyl. Attached to the seat back were two straps. There was a buckle on the straps. Interview with Staff P revealed the "toilet positioning device" was for Resident #17. Staff assisted Resident #17 to use the toilet every two hours. Interview with Staff S on 1/19/15 revealed the devices were made at the facility, there was no schedule for their use, and there was no protocol for checking on Residents when the	W 104		

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W 104	Continued From page 6 device was being used on them. The device had not been assessed for efficacy of its use by anyone qualified. 5. Observation on 1/19/15 at 77 Willow Cottage of a wheelchair belonging to Resident #35 revealed there were food particles, dirt, and grime covering most of the frame of the wheelchair. Resident #35 was also observed with a gait belt around his waist. The gait belt was dirty. The State Surveyor mentioned to Staff QQ the gait belt was dirty and he (Staff QQ) replaced the gait belt with a clean one. Staff QQ was asked who is responsible to clean the wheelchairs and Staff QQ revealed he thought maintenance was in charge of cleaning the wheelchairs. Interview with Staff AA on 1/27/15 revealed the OT/PT department was in charge of cleaning the wheelchairs. 6. Observation on 1/12/15 revealed the front door at 76 Willow Cottage needed to be painted. The exterior window frame located near the front door also needed to be painted. Record review on 1/19/15 revealed the work order to paint the exterior doors and exterior window frames had been placed on 4/11/14.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to develop and implement systems that identified, immediately reported, thoroughly investigated and documented the implementation of protections in	W 122		

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W 122	Continued From page 7 all allegations of abuse/neglect/mistreatment. The facility failed to protect Residents ' rights when they implemented restrictions without assessments and proper abridgements. The failure of the incident management system resulted in an Immediate Jeopardy situation. The Immediate Jeopardy, the failures of the incident management system, and the failure to protect Residents ' rights led to the Condition of Participation of Client Protections to be determined to be Not Met. This potentially affected all Residents served. Findings include: See W125, W127, W130, W148, W149, W150, W153, W154, and W155	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the rights of 17 Residents were protected when they obstructed the view from bedroom windows, used mattresses with lips on the edges, locked doors in a cottage preventing moving about the cottage, locked up Residents ' money, locked up faucet handles to showers, and denied free access to personal belongings without due process. This failure prevented Residents from making an informed decision about how to exercise their rights and determine their need for privacy while	W 125		

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W 125	Continued From page 8 still maintaining the ability to look out their bedroom window. Findings include: 1. Observation on 1/13/15 at Pinewood Cottage at 4:03 PM and at 4:05 revealed bedroom #125 (Residents #30 and #31)and bedroom # 109 (Residents #24 and #32) had opaque panels applied to the windows which went from the bottom of the window to approximately 4/5 of the way to the top of the window, blocking the view out of the window. Interview on 1/13/15 with Staff V revealed the facility had not gone through a rights restriction process prior to blocking the view from the window. 2. Observation on 1/13/15 at Pinewood Cottage at 4:10 PM revealed bedroom #106 (Resident #33) had frosted windows completely blocking the view out of the window. Interview on 1/13/15 with Staff V revealed the facility had not gone through a rights restriction process prior to blocking the view from the window. 3. Observation of Hillside Cottage on 1/12/15 at 3:30 PM revealed Resident #22 ' s bedroom window was completely painted with a holiday scene which obstructed the view out of his bedroom window. Interview with Staff PP on 1/12/15 reported the scene helps decrease Resident #22 ' s [redacted] Staff PP. confirmed four other bedroom windows were painted to ensure privacy and were for decoration. Interview with Staff RR on 1/15/15 at 11:00 AM revealed Resident #22 has a painted bedroom window to ensure privacy. Staff RR further stated Resident #22 does not like to look out of his bedroom window and could use the living room window for viewing outside. 4. Observation of Hillside Cottage on 1/15/15 revealed mattresses with a 2 " to 3 " partial lip or a complete lip on the mattress perimeter used to	W 125		

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W 125	Continued From page 9 prevent Residents from rolling out of bed. Interview with Staff RR acknowledged the lips on the beds were used to prevent residents from falling out of bed. Interview with Staff VV on 1/21/15 at 2:00 PM acknowledged the lips on the mattresses were used to hold the residents in bed. Observation of Hillside on 1/21/15 at 1:30 PM revealed the following residents with mattress beds with approximately a 2 " to 3 " ' inch lip at the head and foot of the mattress: Residents #44, #13, #42, #43, and #39. Resident #36 and Resident #46 had a mattress bed with a 2 " to 3 " inch lip encompassing the entire bed perimeter. Interview with Staff Y on 1/12/15 at 2:00 PM acknowledged old mattresses are now being replaced with pressure reduction mattress some of which have lips. She confirmed that an abridgement of resident rights was not completed as this was a nursing issue. 5. Observation at lunchtime on 1/12/15 at 76/77 Willow Cottage revealed staff exited through a locked door separating the two sides of the cottage. Later the same staff returned through the same locked door. Observation on 1/13/15 revealed Staff Z was observed exiting the dining area through the locked door at 4:45 PM. The same staff was observed returning through the locked door, later. Interview with Staff X on 1/13/15 revealed the door was locked to keep Residents who lived at 77 Willow from interacting with Residents who lived at 76 Willow. Interview with Resident #27 on 1/14/15, who lived at 77 Willow Cottage, revealed he did not have a key to open the locked door. Resident #27 stated he did not know why the door was locked. Resident #27 added if he wanted to visit with friends on the 76 side of Willow Cottage, he had to exit his home and	W 125		

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W 125	Continued From page 10 knock on the door of 76 Willow. Interview with Staff AA on 1/14/15 and Staff X on 1/27/15 revealed the door was locked because the homes were considered two separate residences. They acknowledged staff used keys to unlock the door and travel freely through both sides of the cottage and Residents did not have keys. 6. Observation on 1/12/15 at 88/89 Wildrose Cottage revealed staff unlocked a box that contained money. Staff gave some money to Resident #8. Interview with Staff BBB revealed Resident #8 was going shopping for a coat. Interview with Staff AA on 1/27/15 about the practice of locking up Residents ' money at the house revealed the facility did not view the money in the locked box as actually belonging to Resident #8. Staff AA did acknowledge that if Resident #8 used any of the money kept at the house that it would be charged to his account. 7. Observation on 1/20/15 at 77 Willow Cottage revealed the shower handle was locked inside a plastic box located on the wall of the bathroom. Interview with Resident #3 on 1/20/15 revealed staff unlock the box so he can have the handle to the shower. Review of the IHP dated 9/10/14 for Resident #3 revealed he "self -reliantly showers " . Review of an abridgment dated 9/15/14 revealed the facility had abridged Resident #3's right to shower independently for protective reasons. There was nothing in Resident #3's IHP that indicated he needed protection in the shower. Interview with Staff AA on 1/20/15 stated it was a facility wide practice based on a previous plan of correction. 8. Observation on 1/19/15 at 77 Willow Cottage revealed there was a locked closet called the "Christmas Room " . Staff OO unlocked the closet. Inside the closet were several cases of	W 125		

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W 125	Continued From page 11 soda . Some of the soda belonged to Resident #34. Resident #34 lived at 76 Willow Cottage. Interview with Staff OO revealed Resident #34 was given a specified number of sodas per day. Interview with Staff AA on 1/20/15 revealed Resident #34's rights to have access to the soda she had purchased had been abridged. Staff AA was informed by the State Surveyor that Resident #34's pop was kept in a home she did not live in. Staff AA stated that Resident #34's soda should be kept in her own home. 9. Observation on 1/19/15 at Bigfoot Cottage at 3:00 PM revealed a locked drawer in the kitchen. Interview with the Attendant Counselor Manager (ACM) (Staff U) revealed this drawer contained money for use by the Residents. The ACM verified Resident #6 ' s money was kept in the drawer. Interview on 1/20/15 with the QIDP (Staff W) for Resident #6 verified there was no assessment indicating the need to restrict his access to his money and there was no abridgement of his right to free access to his money.	W 125		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure Residents were not subjected to abuse when Staff A pinched Resident #16 in the chest. This failure resulted in harm to Resident #16 and potentially placed other	W 127		

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W 127	Continued From page 12 Residents receiving care at the facility at risk of abuse. Findings include: 1. Review on 1/15/15 of a facility investigation dated 8/8/14 revealed Staff N observed a bruise on Resident #16's chest . The facility conducted an immediate investigation and questioned Resident #16 about the bruise. Resident #16 stated that on the previous night, 8/7/14, Staff A grabbed him in the chest area when they were "horseplaying" in the kitchen. Further interview of Resident #16 about the incident revealed, he had become "handsy" with Staff A and she "pinched." The facility interviewed Staff A regarding the bruise on Resident #16's chest. Staff A stated the incident started in the living room. Resident #16 was "attempting to push her into a chair." Staff A put her hands on the seat of the chair. Resident # 16 continued to push Staff A into the chair. Staff A stated in her witness statement she "realized" Resident #16 was standing behind her and that she was uncomfortable with him standing behind her while she was bent over in the chair. Staff A reached around with her right hand and pinched Resident #16 in the chest. The bruise was described as a two inch fading purple bruise over the left nipple area. 2. Staff ZZ was interviewed on 1/20/15 at 1:30 PM regarding staff training related to abuse reporting. He acknowledged he provides staff training often including verbal instruction and written information. If a specific policy is referenced in the training, the policy is attached to the attendance sheet. All staff is expected to sign the attendance sheet verifying their participation. Staff ZZ confirmed there was no follow-up to ensure staff reviewed the required written information. Interview with Staff AAA on 1/20/15 at 1:30 PM confirmed that he had not read Protection From	W 127		

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W 127	Continued From page 13 Abuse: Mandatory Reporting Policy 5.13 as indicated on the training sheet he had signed. Staff AAA acknowledged staff are expected to read the attached training material although time to do so is not carved out of staffs ' schedule.	W 127		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure Residents ' privacy was adequately protected when using the bathrooms at Pinewood Cottage. The windows in the bathrooms did not have curtains and the privacy glass windows did not prevent observation of Residents from the outside of the cottage. This failure placed Residents ' privacy at risk when using the bathroom. Findings include: Observation of the bathrooms at Pinewood Cottage on 1/13/15 at approximately 4:15 PM revealed there were no curtains on the windows. The windows were made of a glass designed to protect privacy. However, with further observation it was determined that when standing outside the cottage, it was possible to see sufficient detail through the windows to determine who was standing there as well as what they were wearing. Interview on 1/13/15 with the Attendant Counselor Manager (Staff V) verified there were no curtains on the windows. She stated they had never had curtains on the bathroom windows. She was unaware that privacy was compromised because	W 130		

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W 130	Continued From page 14 the windows did not sufficiently prevent observation of people in the bathroom.	W 130		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to inform guardians of allegations of serious incidents involving 8 Residents (Residents #2, #13, #14, #15, #16, #25, #26, & #29). These incidents were reviewed during assessment of the provider ' s incident management system. This failure prevented guardians from knowing when serious incidents occurred and prevented them from having the opportunity to advocate for them. Findings Include: 1. Staff X was interviewed at 11:55 AM on 01/14/15 with the investigative file related to an allegation of physical abuse involving Resident #13 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #13 occurred on 2/14/14. Staff X confirmed Resident #13 has a legally appointed guardian. Staff X confirmed the facility had no documented evidence the guardian for Resident #13 was informed of the allegation of physical abuse, the corrective actions taken by the facility to protect Resident #13, and/or the outcome of the investigation. Staff X confirmed that none of the internal review systems in place related to	W 148		

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W 148	Continued From page 15 allegations of physical abuse resulted in the identification of the provider ' s failure to notify the guardian of this allegation of physical abuse. 2. Review on 1/15/15 of a Superintendent Five Day Investigation dated 8/30/14 revealed staff observed Resident #13 with an abrasion on the right side of his head. Resident #13 was examined by a facility RN. The wound was considered substantial in nature due to its size and location. The facility implemented an acute nursing care plan that included neuro- checks. There was nothing indicated in the investigation that the guardian was notified that Resident #13 had an injury to his head. Interview with Staff X on 1/27/15 verified the guardian was not notified. 3. Staff X was interviewed at 12:10 PM on 01/14/15 with the investigative files related to an allegation of physical abuse involving Resident #14 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #14 occurred on 2/27/14. Staff X confirmed Resident #14 had a legally appointed guardian. Staff X confirmed the facility had no documented evidence the guardian for Resident #14 was informed of the allegation of physical abuse, the corrective actions taken by the facility to protect Resident #14, and/or the outcome of the investigation. Staff X confirmed that none of the internal review systems in place related to allegations of physical abuse esnured notification of the guardian with regards to allegation of physical abuse. 4. Review on 1/15/15 of a Five Day Investigation dated 4/21/14 revealed Staff Z had been accused of picking up Resident #14 and throwing him into a chair. There was nothing indicated in the investigation record the guardian was notified. Interview with Staff X on 1/27/15 verified the guardian was not notified.	W 148		

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W 148	Continued From page 16 5. At 3:10 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident of verbal abuse directed at Resident #25 which occurred on 6/13/14. With the facility investigation available, Staff X verified the guardian had not been notified of the incident or the actions taken by the facility to protect Resident #25, and that none of the facility ' s internal review systems had ensured the guardian had been notified. 6. At 3:20 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident of verbal abuse related to Resident #16 (who was not present) but was overheard by Resident #2. This incident occurred on 6/22/14. With the facility investigation available, Staff X verified the guardian had not been notified of the incident or the actions taken by the facility to protect Resident #2, and that none of the facility ' s internal review systems ensured notification of the guardian. 7. At 3:30 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident where Resident #26 was aggressive toward others, engaged in self-injurious behavior, was eating inedible items, and had intense suicidal ideation. This incident resulted in a Mental Health Professional (MHP) being called to the facility who determined Resident #26 should be transported to the hospital. This incident occurred on 6/13/14. With the facility investigation available, Staff X verified the guardian had not been notified of the incident or the actions taken by the facility to protect Resident #26, and that none of the facility ' s internal review systems ensured notification of the guardian. 8. Review on 1/15/15 of a facility investigation dated 5/22/14 revealed Staff KK was alleged to have incorrectly administered medication through	W 148		

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W 148	Continued From page 17 Resident #15's G-Tube. Review of the immediate investigation, dated 5/22/14, revealed, under the section title "notifications," the box titled "family surrogate" was not checked. Interview with Staff X on 1/27/15 revealed the guardian/family was not notified. 9. Review on 1/15/15 of a Five Day Investigation revealed Resident #29 stated his chest hurt. A nursing assessment was completed. The nurse documented Resident #29 had the following superficial injuries: multiple superficial ecchymosis (bruising) area to right upper arm, faint ecchymosis to left forearm, a 2 - 3 centimeters faint abraded area to left flank middle back, and a 2 - 3 centimeter round friction type abrasion to the left knee. The facility determined the bruising occurred when Resident #29 and Staff LL fell to the floor. There was nothing in the investigation indicating the guardian was notified of Resident #29 ' s injuries or that Staff LL had been accused of " slamming" Resident #29 to the ground. Interview with Staff X on 1/27/15 revealed the guardian/family was not notified.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement policy which resulted in the immediate reporting of allegations of abuse to Staff X; the thorough investigations of all incidents; and taking protection measures which ensured Residents would not be subjected to further abuse/neglect/mistreatment. This failure	W 149		

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W 149	Continued From page 18 placed all Residents at risk of abuse. Findings Include: Policy Review: The facility ' s policy titled " Protection From Abuse: Mandatory Reporting " identified as Policy 5.13 and dated as issued in September 2011, was reviewed 01/14/15. The section of this policy titled, " Reporting " requires immediate reporting of all allegations of abuse, neglect or exploitation. A " Work Procedure " (LV 10.6), updated on 11/14/13, which " applies to all Lakeland employees and volunteers " provided definitions but did not address the specific requirement of what incidents require immediate notification to Staff X or designee. The section of this Work Procedure titled " Assessment of Incident " documented, " A detailed report completed by an Immediate Investigator that determines and documents the nature of occurrence, type of injury, and initial steps taken to protect health, safety, and property of clients/residents; findings, notifications and action taken. " The Work Procedure is not specific regarding documentation of time corrective actions are put in place, for example, the documentation of the time an alleged perpetrator was removed from contact with Residents served. The " Purpose " section of " Work Procedure " (LV 10.6.A), updated 11/21/13, which " applies to all Lakeland employees and volunteers " documented, " Establish the process for initiating and documenting a client ' s/resident ' s event/incident report, and analyzing client/resident events/incidents in order to take appropriate corrective and preventative measures to protect client/resident health and safety. " This Work Procedure did not include specific instruction to staff regarding documentation of the.	W 149		

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W 149	Continued From page 19 time corrective actions were put in place, for example, the documentation of the time an alleged perpetrator was removed from contact with Residents served. The " Purpose " section of " Work Procedure " (LV 10.6.B), updated on 11/18/13 which " applies to all Immediate Investigators " documented, " To provide for client/resident protection and safety by establishing documentation process for the Immediate Investigation of reported events or incidents and the development of an Immediate Prevention Plan (if appropriate) .... " This Work Procedure did not include specific instruction to staff regarding documentation of the time corrective actions were put in place, for example, the documentation of the time an alleged perpetrator was removed from contact with Residents served. The " Purpose " section of " Work Procedure " (LV 10.6.D), updated on 11/25/13, identified the " Scope " as, " Applies to all Immediate Investigators, Administrative Reviewers and IDT members " documented, " To provide for Client/Resident protection and safety by establishing a documentation process for administrators to review and direct the thorough and complete investigation of reported events or incidents and the development of a Prevention Plan if needed .... " Section " 2.b. " of this Work Procedure documented, " Insure that all appropriate notifications have been made based upon the information in the Secondary Investigation. " The " Family/Surrogate Notification " section of " Work Procedure " (LV 10.6.B), dated as last revised on 11/18/13, which " applies to all Immediate Investigators " documented, " PAT/AP Director or designee will immediately attempt to notify (unless otherwise requested) the	W 149		

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W 149	Continued From page 20 client ' s/resident ' s family or surrogate of any incident, injuries, or illnesses which involved: Physical intervention (diagnosis, treatment plan); Suspected abuse/neglect; ... " 1. Staff X was interviewed at 11:55 AM on 01/14/15 with the investigative file related to an allegation of physical abuse involving Resident #13 available for reference. Staff X confirmed the facility had no documented evidence the legally appointed guardian for Resident #13 was notified of the allegation of physical abuse, the corrective actions taken by the facility to protect Resident #13, and/or the outcome of the investigation in compliance with Work Procedure LV 10.6.B. Staff X confirmed that none of the internal review systems in place related to allegations of physical abuse resulted in the identification of the provider ' s failure to notify the guardian of this allegation of physical abuse in compliance with Work Procedure LV 10.6.D. Staff X confirmed the allegation of physical abuse was documented to have occurred on 2/14/14 at 6:45 PM. and documented notification of Staff X at 8:30 PM on 02/14/14. Staff X confirmed the allegation was not immediately reported to Staff X or designee in compliance with policy 5.13. Staff X confirmed the facility had no documented evidence of the time the alleged perpetrator was removed from contact with Residents which was identified as one of the corrective actions taken. As a result of the failure of the facility to document the time the alleged perpetrator was removed from duty, it was not possible to determine if the one hour and forty-five minute delay in notification of Staff X resulted in the alleged perpetrator remaining on duty with Residents, thereby delaying the implementation of the correction action to protect Residents served in accordance with policy and procedure.	W 149		

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W 149	Continued From page 21 2. Staff X was interviewed at 12:10 PM on 01/14/15 with the investigative files related to an allegation of physical abuse involving Resident #14 available for reference. Staff X confirmed the facility had no documented evidence the legally appointed guardian for Resident #14 was notified of the allegation of physical abuse, the corrective actions taken by the facility to protect Resident #14, and/or the outcome of the investigation in compliance with Work Procedure LV 10.6.B. Staff X confirmed that none of the internal review systems in place related to allegations of physical abuse resulted in the identification of the provider ' s failure to notify the guardian of this allegation of physical abuse in compliance with Work Procedure LV 10.6.D. Staff X confirmed the allegation of physical abuse was documented to have " been discovered " on 2/27/14 at 1:05 PM and documented notification of Staff X at 4:10 PM on 02/27/14. Staff X confirmed the allegation was not immediately reported to Staff X or designee in compliance with policy 5.13. Staff X confirmed the facility had no documented evidence of the time the alleged perpetrator was removed from contact with Residents which was identified as one of the corrective actions taken. As a result of the failure of the facility to document the time the alleged perpetrator was removed from contact with Residents, it was not possible to determine if the two hour and fifty-five minute delay in notification of Staff X resulted in the alleged perpetrator remaining on duty with Residents, thereby delaying the implementation of the correction action in accordance with policy and procedure.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	W 153		

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W 153	Continued From page 22 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to immediately report to Staff X or designee and other officials in accordance with State law 6 of 26 incidents reviewed during Task 2 of the survey. These failures prevented the facility administrator from being able to take immediate protective action and also prevented the State Agency from being informed of incidents in order to ensure Residents were safe. Findings include: 1. Staff X was interviewed at 11:55 AM on 01/14/15 with the investigative file related to an allegation of physical abuse involving Resident #13 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #13 occurred on 2/14/14 at 6:45 PM. Staff X confirmed the investigative file documented notification of Staff X at 8:30 PM on 02/14/14. Staff X confirmed that none of the internal review systems in place related to allegations of physical abuse resulted in the identification of the provider ' s failure to immediately notify Staff X or designee. 2. Staff X was interviewed at 12:10 PM on 01/14/15 with the investigative files related to an allegation of physical abuse involving Resident #14 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #14 was documented as having " been discovered " on 2/27/14 at 1:05 PM. Staff X confirmed the investigative file documented	W 153		

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W 153	Continued From page 23 notification of Staff X at 4:10 PM on 02/27/14. Staff X confirmed that none of the internal review systems in place related to allegations of physical abuse resulted in the identification of the provider ' s failure to immediately notify Staff X or designee of this allegation. 3. At 3:30 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident where Resident #26 was aggressive toward others, engaged in self-injurious behavior, was eating inedible items, and had intense suicidal ideation. This incident resulted in a Mental Health Professional (MHP) being called to the facility and who determined Resident #26 should be transported to the hospital. This incident occurred on 6/13/14. With the facility investigation available, Staff X verified the Complaint Resolution Unit call-in line had not been utilized for this incident. He stated the incident had not been called in as Resident #26 had a Behavior Support Plan (BSP) and the behaviors that occurred during this incident were included in the BSP. 4. At 3:40 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident where Resident #26 engaged in serious self-injurious behavior resulting in the facility calling an MHP to assess Resident #26. The MHP determined Resident #26 should be sent to the hospital. This incident occurred on 7/2/14. With the facility investigation available, Staff X verified the Complaint Resolution Unit call-in line had not been utilized for this incident. He stated the incident had not been called in as Resident #26 had a Behavior Support Plan (BSP) and the behaviors that occurred during this incident were included in the BSP. 5. Review on 1/15/15 of a facility investigation dated 3/26/14 revealed Staff DD observed	W 153		

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W 153	Continued From page 24 bruising on Resident #28's arm on 3/21/14. Staff DD wrote an entry in the Resident s chart but did not report to Staff X regarding the injury of unknown origin. The bruise measured 7 cm by 3cm and was located on her left upper arm. On 3/24/14 Staff EE was contacted by Resident #28's collateral contact. The collateral contact was concerned because she observed the same bruising on Resident #28's arms and she "was alarmed because she observed bruising and it looked like fingerprints." Neither staff DD or EE informed facility administration of the injuries. Staff X and Staff Y were interviewed on 1/17/15 and 1/27/15 about reporting. Staff X and Y confirmed the incident was not reported. 6. While reviewing an investigative file on 1/15/15, the State Surveyor observed an internal e-mail dated 8/31/2104 from Staff FF addressed to Staff GG, Staff A, and Staff HH. The e-mail stated that Staff FF had been given information that Staff JJ was teasing Resident #2 by turning his tape player on and off. Resident # 2 repeatedly asked Staff JJ to stop. Then Staff JJ began poking at him. Then Resident #2 yelled at Staff JJ to stop. The e-mail states: "Considering we all signed an in-service in the past few weeks regarding " horse play as well as our " professional conduct " while at work with the venerable (sic) public we serve this should be addressed swiftly " . The incident was never reported to facility Staff X. Staff X and Staff Y were interviewed on 1/17/15 and 1/27/15 about reporting. Staff X and Y confirmed the incident was not reported.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 25 This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to conduct a thorough investigation of 5 of 26 allegations of abuse/neglect/mistreatment (Residents #13, #14, #16, #25). Failure to do a thorough investigation prevented the facility from fully understanding what happened and to take appropriate corrective action. Findings include: 1. Staff X was interviewed at 11:55 AM on 01/14/15 with the investigative file related to an allegation of physical abuse involving Resident #13 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #13 occurred on 2/14/14 at 6:45 PM. Staff X confirmed the allegation was initiated after an employee reported the perpetrator had " ...kicked/pushed Resident #13 twice causing Resident #13 to fall backwards." Staff X confirmed that during the investigation another allegation against the perpetrator was reported alleging the perpetrator put hand sanitizer in the eyes of Resident #13 approximately one to two weeks prior to the allegation of physical abuse. In addition to the allegation of physical abuse which occurred on 2/14/14, the investigation revealed that the perpetrator also allegedly verbally abused Resident #13 by telling him he wished Resident #13 had " burned up in the fire " in reference to a fire drill conducted earlier in the day on 2/14/14. Staff X confirmed the allegation was submitted for investigation by Washington State Patrol and produced a letter from the State of Washington, Department of Social and Health Services, dated 12/09/14, which documented, " After a Resident and Client Protection Program investigation, the Department of Social and Health Service found	W 154		

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W 154	Continued From page 26 that you abused a vulnerable adult ... " Staff X confirmed the three allegations (the allegation of physical abuse of " kicking/pushing " Resident #13 twice, the allegation of putting hand sanitizer in the eyes of Resident #13 and the allegation of verbal abuse by saying to Resident #13 " he wished he had died in the fire ") were treated as one investigation. Staff X said the determination of abuse was related to kicking/pushing Resident #13 and not the allegation of putting hand sanitizer in the eyes of Resident #13. Staff X confirmed the allegation related to putting hand sanitizer in the eyes of Resident #13, which reportedly happened on or near 02/01/14, was not reported for approximately two weeks and therefore never fully investigated to determine the likelihood the alleged perpetrator might have abused other Residents in the same or a similar manner. 2. At 3:10 PM on 1/20/15 Staff X and Staff Y were interviewed about an incident of verbal abuse directed at Resident #25 which occurred on 6/13/14. Embedded in the facility investigation is a statement that a staff was smoking on the patio of the cottage. This is a violation of State law, RCW 70.160.075. The facility did not pursue this information as part of the investigation. With the facility investigation available, Staff X verified the facility had not thoroughly investigated all aspects of the incident. 3. Review on 1/15/15 of a facility investigation dated 8/8/14 revealed Staff N observed a bruise on Resident #16's chest on 8/8/14. The facility conducted an immediate investigation and questioned Resident #16 about the bruise. Resident #16 stated that the previous night, 8/7/14, Staff A grabbed him in the chest area when they were "horseplaying" in the kitchen. Further interview of Resident #16 about the	W 154		

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LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 154	Continued From page 27 incident revealed, he had become "handsy" with Staff A and she "pinched." The facility interviewed Staff A regarding the bruise on Resident #16's chest. Staff A stated the incident started in the living room. Resident #16 was "attempting to push her into a chair." Staff A put her hands on the seat of the chair. Resident # 16 continued to push Staff A into the chair. Staff A stated in her witness statement she "realized" Resident #16 was standing behind her and that she was uncomfortable with him standing behind her while she was bent over in the chair. Staff A reached around with her right hand and pinched Resident #16 in the chest. The bruise was described as a two inch fading purple bruise over the left nipple area. Resident #16 stated staff and Residents were present when the incident occurred. Staff A stated she was unsure if anyone was present. The facility did not interview any potential witnesses. The facility did not determine why Resident #16 stated the incident occurred in the kitchen area and Staff A stated it occurred in the living area of the home. The facility investigation did not determine why Staff A did not report she had pinched Resident #16 in the chest area. The facility investigation determined staff engaged in " horseplay " with Resident #16. The facility does not describe what occurred during the "horseplay," or determine exactly what Staff A was doing prior to being pushed into the chair. Staff X and Y were interviewed on 1/17/15 and 1/27/15 about the investigation. Staff X and Y acknowledged the investigation did not contain the above mentioned elements as well as all information which would allow the facility to know exactly what happened.	W 154		

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W 154	Continued From page 28 4. Review on 1/15/15 of a Superintendent five day investigation dated 8/30/15 revealed staff from the am shift reported to the pm shift that Resident #13 had an abrasion on the right side of his head. Resident #13 was examined by a facility RN. The wound was considered substantial in nature due to its size and location. The facility investigation was not thorough because the facility did not interview any staff working with Resident #13 the day the injury was discovered. Staff X and Y were interviewed on 1/17/15 and 1/27/15 about the investigation. Staff X and Y acknowledged the investigation did not contain interviews of staff who worked with Resident #13 that day. 5. Review on 1/15/15 of a Five Day investigation dated 4/21/14 revealed Staff Z had been accused of picking up and throwing Resident #14 into a chair. The investigation included interviews of the witness, the accused staff and one additional staff who filled out the restraint log. The investigation did not reveal that any other staff working the evening the incident allegedly occurred were interviewed. Staff X and Y were interviewed on 1/17/15 and 1/27/15 about the investigation. Staff X and Y acknowledged the investigation did not contain interviews of all staff who worked with Resident #13 that day.	W 154		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record reviews, the	W 155		

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W 155	Continued From page 29 facility failed to document the implementation of protective actions to prevent further potential abuse during the investigations of physical abuse by a facility employee for 4 Residents (Residents #13, #14, #15, & #16). This failure to document protective measures during the investigations placed Residents at risk of further harm. Findings Include: 1. Staff X was interviewed at 11:55 AM on 01/14/15, with the investigative file related to an allegation of physical abuse involving Resident #13 available for reference. Staff X confirmed the allegation of physical abuse involving Resident #13 occurred on 2/14/14 at 6:45 PM and documented notification of Staff X at 8:30 PM on 02/14/14. Staff X confirmed he generally advised staff to remove alleged perpetrators from duty or confirmed the actions taken by supervisory staff who had removed alleged perpetrators from contact with Residents prior to calling. Staff X confirmed the facility had no documented evidence of the time the alleged perpetrator was removed from contact with Residents. Staff X confirmed that one of the corrective actions was to remove the alleged perpetrator from contact with Resident. The facility failed to immediately remove the alleged perpetrator from resident contact. It was not possible to determine if the one hour and forty-five minute delay in notification of Staff X resulted in the alleged perpetrator remaining on unsupervised duty with Residents. This situation delayed the facility's implementation of the correction action to protect the Residents. Staff X confirmed that the facility's internal review systems related to allegations of physical abuse failed to identify the provider's failure to document the time corrective actions were implemented. 2. Staff X was interviewed at 12:10 PM on	W 155		

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W 155	Continued From page 30 01/14/15 with the investigative files available for reference related to an allegation of physical abuse involving Resident #14. Staff X confirmed the allegation of physical abuse involving Resident #14 was documented as having " been discovered " on 2/27/14 at 1:05 PM and documented notification of Staff X at 4:10 PM on 02/27/14. Staff X confirmed the facility had no documented evidence of the time the alleged perpetrator was removed from contact with Residents, this step was identified as one of the corrective actions taken. As a result of the failure of the facility to document the time the alleged perpetrator was removed from duty, it was not possible to determine if the two hour and fifty-five minute delay in notification of Staff X resulted in the alleged perpetrator remaining on duty with Residents. Lack of documentation delayed the implementation of the corrective action. Staff X confirmed that the facility's internal review systems in place failed to identify the provider's failure to document the alleged perpetrator's reassignment were implemented. 3. Review on 1/15/15 of a facility investigation dated 8/8/14 revealed Staff N observed a bruise on Resident #16's chest on 8/8/14. The facility conducted an immediate investigation and questioned Resident #16 about the bruise. Resident #16 stated that the previous night, 8/7/14, Staff A grabbed him in the chest area when they were "horseplaying" in the kitchen. Further interview of Resident #16 about the incident revealed he had become "handsy" with Staff A and she "pinched." The facility interviewed Staff A regarding the bruise on Resident #16's chest. Staff A stated the incident started in the living room. Resident #16 was "attempting to push her into a chair." Staff A put her hands on the seat of the chair. Resident #	W 155		

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W 155	Continued From page 31 16 continued to push Staff A into the chair. Staff A stated in her witness statement she "realized" Resident #16 was standing behind her and that she was uncomfortable with him standing behind her while she was bent over in the chair. Staff A reached around with her right hand and pinched Resident #16 in the chest. The bruise was described as a two inch fading purple bruise over the left nipple area. Review of the facility Modified Reassignment Letter, dated 8/8/14, revealed the facility allowed Staff A to continue working with Residents. The letter instructed her to work in areas where staff were present like "on the cottage ". Staff A could take Residents on outings or appointments, as long as there was another staff with her, and the other staff was also not on modified reassignment. 4. Review on 1/15/15 of a facility investigation dated 5/22/14 revealed Staff KK was alleged to have incorrectly administer medication through Resident #15's G-Tube. Review of the Modified Reassignment letter dated 5/22/14 revealed Staff KK was placed on modified reassignment. Interview with Staff X revealed Staff KK was only removed from working with residents who received medications or nourishment through a G-Tube. 5. Review on 1/15/15 of a facility investigation dated 7/10/14 revealed staff KK was accused of "aggressively/forcefully feeding/administering medications to Resident #15. Staff KK was placed on "modified re- assignment." Review of an email dated 7/31/2014 revealed Staff X released Staff KK from modified re-assignment. Interview with Staff X on 1/16/15 and 1/27/15 verified Staff KK was placed on modified reassignment and only removed from working with residents who received medications or	W 155		

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W 155	Continued From page 32 nourishment through a G-Tube.	W 155		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient staff were available in order to meet the needs of four Residents (Residents #4, #11, #17 & #47). This failure placed Residents at risk of not having their needs met. Findings include: The Condition of Participation of Active Treatment Services was found " Not Met. " Please refer to W196 for specific details of observations conducted for Resident #4 and Resident #11. Presented below is a summary of the times and dates of those observations. 1. During observation on Apple cottage from 10:50 AM to 12:20 PM on 1/12/15, neither Resident #4 nor Resident #11 was observed to be consistently involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 3:25 PM to 4:45 PM on 1/12/15, neither Resident #4 nor Resident #11 were observed to be consistently involved in an active treatment program intended to teach skills or increase independence. During observation on Apple	W 186		

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W 186	Continued From page 33 cottage from 6:30 AM to 9:00 AM on 1/13/15, neither Resident #4 nor Resident #11 were observed to be involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 8:50 AM to 12:00 PM on 1/13/15, neither Resident #4 nor Resident #11 were observed to be involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime and, for Resident #4, a four minute period of time when a walking program was initiated. During the observation at Apple Cottage on 01/14/15 from 8:50 AM to 12:00 PM, after watching Resident #11 walk around the residence without being offered programmatic or leisure time activities or support and after having observed Resident #4 sit for long periods of time without being offered programmatic or leisure time activities or support beyond magazines and books typically in his possession, Staff C was asked what Resident #11 and Resident #4 would be doing this morning. Staff C said it was too late for PDT [programming and leisure activities designed to be provided by residential staff] because the staff had to start relieving each other for lunch. Staff C explained that one man had a community medical appointment this morning and, due to a behavioral outburst exhibited by a non-sampled client the previous night which resulted in the need to provide a higher level of supervision for that Resident, there was no way to take the men off the cottage for programming or leisure activities. When asked if the staff who worked in the day programming area ever came to the cottage to escort the men to on-campus activities, Staff C said although one non-sampled	W 186		

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W 186	Continued From page 34 Resident who lived at Apple Cottage was escorted to work by vocational staff, most of the time, unless the " student helpers " were available, no one from the day program assisted the residential staff assigned to Apple Cottage. When asked specifically about Resident #4 and Resident #11, Staff C said if/when these men participated in activities off the residence, residential staff would take them. When asked if either man would participate in any programming off the residence during first shift today, Staff C replied, " Probably not, we just don ' t have enough people because.... " and explained the changing support needs of the various men who lived at Apple Cottage. Staff C also pointed out that at 9:39 AM, the beeper worn by Staff B alarmed and Staff B left Apple Cottage to respond to a " behavior emergency. " According to Staff C those were the types of things that made it virtually impossible to provide individualized activities on an on-going basis. Staff MM was interviewed at 7:40 AM on 01/16/15. When asked to explain " staff coverage ", Staff MM contacted Staff NN via telephone allowing the interview to include both direct support professionals. Staff NN explained that first and second shifts were always " worked " with at least six direct support staff, and third shift with at least two direct support staff. According to Staff NN although the ratios were consistently " met " the needs of the men who lived at Apple Cottage and the various responsibilities of the staff (such as taking Residents served to appointments in the community as well as on-campus, the need to maintain one-on-one coverage based on the needs of the Residents served, the need to address health related and medical needs such as convalescence from surgery, sprained ankles,	W 186		

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W 186	Continued From page 35 high blood pressure, diabetes monitoring, etc.), it was not possible to consistently implement individual programming and offer a wide variety of leisure time activities based on individual preferences and needs for the men living at Apple Cottage. Staff NN confirmed it was not an issue of staff " sitting around doing nothing " (substantiated during all observations as staff consistently went from assisting one Resident served to another, setting up meals or providing alternative food choices, assisting Residents served with personal care needs, etc.) but rather the always changing needs of the Residents served. According to Staff NN although the day program was intended to allow great flexibility, the day to day tasks of getting people to appointments, meeting the health and hygiene needs of the Residents served, assuring that meals and snack were served consistent with diet orders and " on time, " and assuring all staff received time away for meals and breaks interfered with consistent implementation of programs and leisure time opportunities. 2. Observation on 1/20/15 of two bathrooms used by Resident # 17 at her adult training area revealed there were two bathrooms used by residents. One bathroom (O63P) contained a toilet that had a toilet positioning device seat restraint mounted to it and the other did not. Interview with Staff Q revealed she used either toilet when she assisted Resident #17 to use the bathroom. She added that she would usually stay with Resident #17 while she used the toilet. Staff Q stated she would use the toilet positioning device if she could not stay with Resident #17 while she used the toilet. 3. Observation on 1/15/15 at Evergreen Cottage at 11:20 AM revealed Residents were being asked to gather their plates, cups and silverware	W 186		

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W 186	Continued From page 36 and set the table. Resident #47 asked to eat at the "Wrangle Inn" (a buffet provided by the facility adjacent to the main kitchen). Staff CCC told her she could not go because there was no staff available to take her there. Staff asked Resident #47 to gather her dishes and set them at the table. Resident #47 sat at the table with her dishes. Staff DDD stated Resident #47 could go the next day because he would be available to take her. A few minutes later, Staff EEE appeared at the house. Staff CCC stated you can go to the "Wrangle Inn ". Staff EEE assisted Resident #47 to get her coat on.	W 186		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a system to assure staff received training and consistently demonstrated competency to implement the individual program plan for one of one Resident (Resident #4) in the sample who was recovering from a fractured hip. The failure of the facility to train staff placed Residents at risk of not having their health care needs met. Findings Include: Observation was initiated at 10:50 AM on 01/12/15 at Apple Cottage. Resident #4 was lying on a mat in the living room of his residence. He was wearing a gait belt positioned about two inches below his breasts. At 11:36 AM Staff B and Staff C transferred Resident #4 to a	W 192		

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W 192	Continued From page 37 wheelchair and assisted him to the dining room for lunch. The gait belt was not used during this transfer. At 11:53 AM, Resident #4 was transferred from his wheelchair to the mat by staff Staff B and Staff H in the living room. The gait belt was not used during this transfer. The gait belt was not removed once Resident #4 was transferred to the mat. Observation was initiated at 3:25 PM on 01/12/15 at Apple Cottage. Resident #4 was seated in a recliner with his feet elevated. Resident #4 was wearing a gait belt which was positioned approximately two inches below his breasts. At 3:38 PM, Staff F assisted Staff E to transfer Resident #4 to a wheelchair. The gait belt was not used during the transfer nor was it removed once Resident #4 was seated in his wheelchair. At 3:44 PM, Staff E and Staff G and, transferred Resident #4 to a recliner. The gait belt was not used during the transfer nor was it removed once Resident #4 was seated in the recliner. Observation was initiated at 6:30 AM on 01/13/15 at Apple Cottage. At 8:21 AM, Resident #4, seated in his wheelchair, was brought into the dining room by Staff B Resident #4 was wearing a gait belt positioned approximately three inches below his breasts. Staff B assisted Resident #3 to transfer to a dining room chair at 8:24 AM. The gait belt was not used during the transfer nor was it removed or adjusted when Resident #4 was seated in the dining room chair. At 8:33 AM, Staff B and Staff I, transferred Resident #4 from the dining room chair to his wheelchair, pushed Resident #4 in his wheelchair in the living room and at 8:35 AM transferred Resident #4 from his wheelchair to a recliner. The gait belt was not used during the transfer nor was the gait belt removed once Resident #4 was seated in the recliner.	W 192		

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W 192	Continued From page 38 Observation was initiated at 8:50 AM on 01/13/15 at Apple Cottage. Resident #4 was seated in a recliner in the living room. He was wearing a gait belt positioned approximately two inches below his breasts. At 9:01 AM, Resident #4 dropped on his knees in front of the recliner and crawled from the recliner to the corner of the room and laid down. At 9:14 AM, Staff B and Staff C transferred Resident #4 into his wheelchair then to a recliner. The gait belt was not used during the transfers and was not removed once Resident #4 was seated in the recliner. At 9:26 AM, Resident #4 appeared to be asleep sitting in the recliner with his feet elevated and the gait belt on. Staff C confirmed he had not received training related to the use of the gait belt worn by Resident #4. Staff C said he was unaware of any written instruction about the use of the gait belt. Staff C said he did not know when the wheelchair was to be used and when Resident #4 was to be encouraged to walk with assistance. At 10:16 AM, Staff J, approached Resident #4 and asked if he wanted " to take a walk. " Staff J and Staff B helped Resident #4 stand up. Both staff assisted Resident #4 to walk approximately 30 feet prior to transferring him back into his wheelchair at 10:20 AM. The gait belt was used to assist Resident #4 while walking. At 10:28 AM, Resident #4 was transferred back to the recliner. He continued to wear the gait belt. At 10:29 AM, Staff J said she had not received client specific training about the use of the gait belt and/or the wheelchair to assist Resident #4 as he recovered from his surgically repaired fracture. Staff J confirmed she had not received training or instructions about how often or the distance Resident #4 should be walking. Staff J confirmed neither she nor other staff assigned to Apple Cottage received training on the supports and	W 192		

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W 192	Continued From page 39 services needed to assist Resident #4 to walk more and rely less on the wheelchair. Resident #4 remained seated in the recliner until 11:30 AM, at which time Staff B and Staff J transferred him to his wheelchair and assisted him to the dining room and transferred him to a dining room chair. The gait belt was not used in either transfer. Resident #4 finished lunch at 11:48 AM at which time he was transferred from the dining room chair to his wheelchair and from his wheelchair to the recliner. The gait belt was not used during either transfer. At 12:00 PM, when the observation ended, Resident #4 appeared to be asleep sitting in the recliner wearing the gait belt which was positioned approximately three inches below his breasts. Observation was initiated at 5:00 PM on 01/14/15 at Apple Cottage. Resident #4 was lying on a mat on the floor directly under the wall mounted television in the living room. Resident #4 appeared to be asleep and had a blanket over his head. At 5:57 PM, Resident #4 was transferred to his wheelchair by Staff K and Staff E. Although Resident #4 was wearing a gait belt, it was not used during the transfer. At the conclusion of his evening meal at 6:20 PM, Resident #4 was transferred from the dining room chair to his wheelchair and then to his recliner by Staff K and Staff E. The gait belt was not used during the transfer. From 6:20 PM to 6:35 PM, Resident #4 sat in the recliner with his head down. He was wearing the gait belt. At 6:35 PM, Resident #4 appeared to be asleep sitting in his recliner and remained that way until 7:00 PM at the time the observation was concluded. The Habilitation Plan Administrator Staff X who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4 was interviewed at 11:25 AM on 01/15/15 with	W 192		

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W 192	Continued From page 40 Resident #4 ' s record available for reference. The QIDP explained on 08/31/14, Resident #4 fell from a toilet seat and sustained a fracture. According to the QIDP, Resident #4 ' s fracture was surgically repaired and he remained in the community hospital until 09/05/14. The QIDP confirmed once returned to his residence, Resident #4 participated in Physical Therapy. The QIDP confirmed although Resident #4 no longer received " direct " physical therapy, this IHP was not amended to include who was responsible for training staff to implement the walking program and who was responsible for assuring staff demonstrated competency to administer the walking program. The QIDP confirmed the team had not discussed a mechanism whereby staff would be trained and monitored to assure proper use of the gait belt and wheelchair. The QIDP confirmed there was no system developed to assure all staff were trained on the specifics of the walking plan and no oversight to assure the walking plan was properly implemented in order to assist Resident #4 to regain mobility and rely less on the use of a wheelchair. Record Review for Resident #4 was conducted on 01/16/15 at 6:30 AM. Resident #4 ' s record included an email dated, 12/22/14, to the QIDP from a Physical Therapist documenting Resident #4 would be discontinued from physical therapy services. The email included a recommendation which documented, " I recommend that staff continue to walk with [Name of Resident #4] using a gait belt and two hands held with one staff following with wheelchair for mobility on the cottage. " The record for Resident #4 did not include information about how staff were to be trained and/or who was responsible for monitoring.	W 192		

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W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement systems that resulted in Residents receiving consistently implemented plans based on functionally assessed needs and which promoted self-management. The lack of consistently implemented plans prevented the residents from receiving necessary services and supports to promote greater autonomy and independence and resulted in the Condition of Participation of Active Treatment Services to be not met. Findings include: See W196	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure three of twelve sampled Residents (Residents #4, #9 and #11)	W 196		

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W 196	Continued From page 42 received a continuous, consistently implemented program of supports and services to meet health related and training needs. Failure to ensure Residents are provided active treatment prevented Residents from acquiring skills to increase their independence. Findings include: 1. Resident #4: Observation on Monday, 01/12/15: 10:50 AM to 12:20 PM: Observation was initiated at 10:50 AM on 01/12/15 at Apple Cottage. Resident #4 was lying on a mat on the living room floor of his residence. He was lying on his stomach and appeared to be asleep. Resident #4 remained lying on the mat without staff intervention or contact until 11:36 AM at which time two staff members Staff B and Staff C transferred Resident #4 to a wheelchair and assisted him to the dining room for lunch. From 11:36 AM to 11:53 AM, Resident #4 was observed to take medication and to eat his lunch. At 11:53 AM, Resident #4 was transferred from his wheelchair to the mat in the living room by Staff B and Staff H. After being transferred to the mat, Resident #4 covered his body, including his head, with a blanket. Resident #4 remained on the mat covered with a blanket until the conclusion of the observation at 12:20 PM. During this one and one-half hour observation, other than the seventeen minute period of time during which he received medication administered by Staff D and when he received assistance with mealtime by Staff B, Resident #4 was not observed to be involved in any activities intended to teach skills or increase independence. 3:25 PM to 4:45 PM: Observation was initiated at 3:25 PM on 01/12/15 at Apple Cottage. Resident #4 was seated in a	W 196		

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W 196	Continued From page 43 recliner with his feet elevated. The television remote was in his lap. At 3:32 PM, as a non-sampled Resident walked into the living room making loud vocalizations, Resident #4 opened his eyes and threw the television remote on the floor. At 3:38 PM, Staff E asked Resident #4 if he wanted to play a game with her. Resident #4 replied, "Yes." Staff F assisted Staff E to transfer Resident #4 to a wheelchair. As Staff E was setting up a game to play with Resident #4, a non-sampled resident walked by the dining room table and pushed the game on the floor. Staff E explained to Resident #4 that they would have to play a game later. She pushed Resident #4 in his wheelchair back to the living room and Staff G assisted Staff E to transfer Resident #4 to a recliner. Resident #4 was handed a green cloth bag containing books and a stack of paper magazines which included pictures of cars. Resident #4 remained in the recliner and appeared to be asleep until the conclusion of the observation at 4:45 PM. During this one hour and twenty minute observation, Resident #4 was not observed to be involved in any activities intended to teach skills or increase independence. Observation of Tuesday, 01/13/15: 6:30 AM to 9:00 AM: Observation was initiated at 6:30 AM at Apple Cottage. Staff I confirmed Resident #4 was asleep in his room. At 8:12 AM, Staff I confirmed Resident #4 was asleep in his room. At 8:21 AM, Resident #4 was brought into the dining room by Staff B. Resident #4 was seated in his wheelchair. Staff B assisted Resident #4 to transfer to a dining room chair at 8:24 AM. Resident #4 completed his meal at 8:33 AM. Staff B, assisted by Staff I, transferred Resident #4 from the dining room chair to his wheelchair, pushed Resident #4 in his wheelchair to the living	W 196		

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W 196	Continued From page 44 room and at 8:35 AM transferred Resident #4 from his wheelchair to a recliner. Staff B raised the feet on the recliner, handed Resident #4 the green cloth bag containing books and the stack of magazines with pictures of cars used by Resident #4 during observations the previous day. Resident #4 remained in the recliner without staff interaction from 8:35 AM until the conclusion of the observation at 9:00 AM at which time Resident #4 appeared to be asleep. During the thirty-nine minute time period when Resident #4 was awake and out of his bedroom during this two and one-half hour observation, with the exception of the eleven minutes when Resident #4 was assisted with breakfast, Resident #4 was not observed to be involved in an active treatment program intended to teach skills or increase independence. Observation of Wednesday, 1/14/15: 8:50 AM to 12:00 PM Observation was initiated at 8:50 AM on 01/13/15 at Apple Cottage. Resident #4 was seated in a recliner in the living room. He was manipulating a stack of magazines with pictures of cars. A green cloth bag containing books was placed at his left side in the seat of the recliner. Although the television affixed to the wall in front of the recliner where Resident #4 was seated was on, Resident #4 did not appear to be watching. Resident #4 's head was down although his eyes were open. Although the magazines with pictures of cars were in his lap, he did not appear to be looking at them. At 9:01 AM, Resident #4 dropped on his knees in front of the recliner. Staff H, who was providing one-on-one supervision of a non-sampled Resident who was in the dining room, established visual contact with Resident #4 and remarked, " [Name of Resident #4], you should be in your	W 196		

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W 196	Continued From page 45	W 196		

chair." Resident #4 did not respond. At 9:05 AM, Resident #4 was still on the floor on his knees in front of the recliner. He had spread out the copies of the magazines with pictures of cars in front of him on the floor. At 9:07 AM, Staff H said to Resident #4, "Hey, Mr. [Resident #4 's last name], where are you going?" Resident #4 did not respond. At 9:08 AM, Resident #4 crawled from the recliner to the corner of the room and laid down on the floor, on his stomach, still clutching some of the magazines. At 9:09 AM, Staff H prompted Resident #4 and said, "Where are you going?" Resident #4 did not respond. At 9:10 AM, Staff B, who had been assisting another resident in the bathroom, came into the dining room and was advised by Staff H that Resident #4 was lying on the floor and needed assistance. At 9:12 AM, Staff B approached Resident #4 and told him that he would get him a mat to lie on if he wanted to lie on the floor. Resident #4 did not respond. At 9:14 AM, Staff B and Staff C moved some of the furniture in the living area in order to position themselves in a manner to safely transfer Resident #4 to his wheelchair. Staff B and Staff C transferred Resident #4 into his recliner and handed him the green cloth bag containing books and the magazines with pictures of cars which they gathered up from the floor. Staff B turned the television on, turned off the living room light and left the living room to assist with a non-sampled client who was pushing objects off shelves. At 9:26 AM, Resident #4 appeared to be asleep sitting in the recliner.

At 9:47 AM, Staff C was asked what Resident #4 would be doing this morning. Staff C said it was too late for PDT [programming and leisure activities designed to be provided by residential staff] because the staff had to start relieving each

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W 196	Continued From page 46 other for lunch. Staff C explained one man had a community medical appointment this morning and that due to a behavioral outburst exhibited by a non-sampled client the previous night which resulted in proving a higher level of supervision for that Resident, there was no way to take the men off the cottage for programming or leisure activities. When asked if Resident #4 would participate in any programming off the residence during first shift today, Staff C replied, " Probably not, we just don ' t have enough people ... " At 10:11 AM, Resident #4 appeared to be looking at the car magazines. At 11:12 AM, while providing one-on-one supervision to a non-sampled client, Staff H asked Resident #4 if he wanted to show the surveyor his favorite car. Resident #4 did not respond to the request. Staff H explained that yellow was Resident #4 ' s favorite color and he particularly liked yellow cars. Resident #4 did not respond to the exchange of information about yellow cars. At 10:14, Resident #4 began making very loud vocalizations. At 10:16 AM, Staff J approached Resident #4 and asked if he wanted " to take a walk. " Resident #4 smiled at Staff J and she and Staff B helped him stand up and both assisted in walking with him for approximately 30 feet prior to transferring him back into his wheelchair at 10:20 AM. Resident #4 sat in his wheelchair near the medication room for approximately eight minutes while staff responded to the behavior of a non-sampled resident. At 10:28 AM, Resident #4 was transferred back to the recliner. He was handed the green cloth bag containing books and the car magazines. Resident #4 remained seated in the recliner, with no staff interaction, until 11:30 AM, at which time Staff B and Staff J transferred him to his wheelchair and assisted him to the dining	W 196		

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W 196	Continued From page 47 room for lunch. Resident #4 finished lunch at 11:48 AM at which time he was transferred from the dining room chair to his wheelchair and from his wheelchair to the recliner. At 12:00 PM, when the observation ended, Resident #4 appeared to be asleep sitting in the recliner with his feet elevated. The green cloth bag was placed beside him in the chair and the car magazines were on his lap. During this three hour and ten minute observation, Resident #4 was not observed to be involved in an active treatment program intended to teach skills or increase independence with the exception of the walking program initiated for four minutes and when Resident #4 received assistance with lunch for eighteen minutes. 5:00 PM to 7:00 PM Observation was initiated at 5:00 PM on 01/14/15 at Apple Cottage. Resident #4 was lying on a mat on the floor directly under the wall mounted television in the living room. Resident #4 appeared to be asleep and had a blanket over his head. Resident #4 remained asleep on the mat on the floor covered with a blanket until 5:57 PM at which time he was transferred to his wheelchair by Staff K and Staff E. Resident #4 was provided support by various staff from 5:57 PM until the conclusion of his evening meal at 6:20 PM. At 6:20 PM, Resident #4 was transferred from the dining room chair to his wheelchair and then to his recliner by Staff K and Staff E. Once seated in his recliner, Resident #4 was handed the green cloth bag with books and the car magazines. Although the television was on in the living room, Resident #4 did not appear to be watching. From 6:20 PM to 6:35 PM, Resident #4 sat quietly in the recliner with his head down. At 6:35 PM, Resident #4 appeared to be asleep sitting in his recliner and remained	W 196		

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W 196	Continued From page 48 that way, with no staff interaction, until 7:00 PM at which time the observation was concluded. During this two hour observation, Resident #4 was not observed to be involved in an active treatment program intended to teach skills or increase independence with the exception of the twenty-three minute period of time he received mealtime supports. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4, was interviewed at 11:25 AM on 01/15/15 with Resident #4 ' s record available for reference. The QIDP confirmed the current Individual Habilitation Plan (IHP) for Resident #4 was held on 08/07/14 and included three objectives on which data were maintained. The QIDP said the first objective related to scooping food from a serving bowl. The QIDP said the second objective related to hair washing. The QIDP said the third objective related to reducing the frequency of aggression. When told of the observations of Resident #4 spending long periods of time on the mat on the living room floor as described above, the QIDP confirmed that on 12/31/14, the team for Resident #4 requested an evaluation for depression. The team cited the behavior of electing to rest on a mat on the floor for long periods of time and the fact that he was not currently on an anti-depressant medication, as partial reasons for the referral. When asked if the team had identified, through the assessment process, the types of on-campus and off-campus activities Resident #4 enjoyed, the QIDP said there was a section in the IHP which addressed that. When asked if the team for Resident #4 had created an individualized active treatment program for him predicated on assessed skills, interests and preferred activities designed to teach skills and/or lessen the likelihood of	W 196		

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W 196	Continued From page 49 Resident #4 losing skills, the QIDP said Resident #4 ' s plan was not specific. When asked about the team ' s expectation for participation in preferred activities beyond the formalized objectives related to scooping food, personal hygiene and reducing aggression, the QIDP explained other activities were done on an " informal basis " when opportunities were presented. The QIDP confirmed there was no documented evidence of the frequency or type of activities offered to Resident #4 beyond assuring he had access to the car magazines. Record Review for Resident #4 was conducted on 01/16/15 at 6:30.AM. Resident #4 ' s record included an IHP, dated 8/7/14. The " Social Needs " section of his IHP documented, " When in the mood, [Name of Resident #4] enjoys activities including going to dances, going for walks, watching television and VCR tapes (e.g., the Wiggles series). He likes to interact with staff and will greet people as they come to his home. [Resident #4] likes praise and enjoys a good joke. He likes carrying copies of the Wheels Deals magazines and finds Volkswagen bugs if requested. " The " Day Program " section of the IHP documented, " [Resident #4] used to attend the recycling center at Adult Programs, however due to continual refusals and assaultive behaviors when he did go, Adult Programs were discontinued on 04/26/06. Direct Care staff continue to offer him the opportunity to go to the Adult Training area when his peers are going to work, and at times he will be agreeable and go with them. If [Resident #4] begins to show a consistent interest in participating in Adult Training activities, a referral will be sent to that area for assessment. " During the interview with the QIDP on 1/15/15, a copy of a document titled " Monthly Progress	W 196		

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W 196	Continued From page 50 Report of the Resident Habilitation Plan " (Monthly Review) was provided for review. Although the document was not dated, when presented for review, the QIDP identified the document as the " most current " review of Resident #4 ' s IHP and included a review of December 2014 data. The Section of the report titled, " Non-Programmed Services " documented, " When [Resident #4 chooses to sleep on the mat on the living room floor, offer him alternative activities every 15 minutes to encourage him to participate in activities of daily living: Review annually. " 2. Resident #11: Observation on Monday, 01/12/15: 10:50 AM to 12:20 PM: Observation was initiated at 10:50 AM at Apple Cottage. Throughout the observation, with the exception of when Resident #11 was assisted with lunch between 11:32 AM - 11:46 AM, Resident #11 walked around the residence. Resident #11 continually walked through the residence going from the living room, through the dining room, sometimes into his bedroom for a brief period of time, then down the hallway and through the living room. He was wearing sweat pants and often placed his hands on the waistband of his sweat pants pulling them down to expose the disposable brief he wore. Although sometimes when he passed the primary door used by staff and Residents which leads to the outside, he only looked out the window, on three different occasions during the one and one-half hour observation, Resident #11 walked outside without putting on a coat (the weather was cold as evidenced by all Residents served leaving the residence being promoted or assisted with wearing a winter coat). Once verbally prompted,	W 196		

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W 196	Continued From page 51 Resident #11 came inside and resumed walking around. At 11:32 AM, Resident #11 was verbally and physically prompted by Staff L to bring his dishes to the table for lunch. Resident #11 completed his meal at 11:46 AM. During this one and one-half hour observation, other than the fourteen minute period of time when he received assistance with lunch, Resident #11 was not observed to be involved in an active treatment program intended to teach skills or increase independence. 3:25 PM to 4:45 PM: Observation was initiated at 3:25 PM at Apple Cottage. Resident #11 was walking around the residence with his coat on. At 3:30 PM, Resident #11 grabbed Staff M by the arm and attempted to hit her. Resident #11 was redirected by Staff M and Staff E distracted Resident #11 by prompting him to remove his coat and hang it up. Resident #11 removed his coat, dropped it on the floor by the front door and continued to walk around the residence. At 4:15 PM, Resident #11 pulled his sweat pants down around his ankles and began pulling on the disposable brief he was wearing. Staff F assisted Resident #11 with pulling up his sweat pants and directed Resident #11 to the bathroom. During this one hour and twenty minute observation, other than being prompted to take off his coat and hang it up and when taken to the bathroom, Resident #11 was not observed to be involved in an active treatment program intended to teach skills or increase independence. Observation on Tuesday, 01/13/15: 6:30 AM to 9:00 AM: Observation was initiated at 6:30 AM at Apple Cottage. Staff I confirmed Resident #11 was asleep in his room. When asked what Resident #11 would be doing today, Staff I reported	W 196		

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W 196	Continued From page 52 Resident #11 worked at recycling only on Mondays so today he would be involved in activities at home and, if possible, at another building on campus. Staff I said Resident #11 was supposed to participate in activities either at the residence or at the Adult Program building but explained that the " cottage staff " were expected to take Residents to on-campus and off-campus appointments, meet the behavior support needs of the men who lived at Apple Cottage and who exhibited aggressive and/or assaultive behavior, provide one-on-one supervision for one non-sampled client, and provide one-on one coverage for one non-sampled client during mealtimes, as well as covering meal and break times for employees. When asked what types of activities Resident #11 liked to do, Staff I explained that " mainly " Resident #13 just liked to " walk around. " Staff I reported Resident #11 enjoyed going to the " Movie Room. " When asked how often Resident #11 went to the movie room, Staff I said it depended on the number of staff on duty and " how things were going at the cottage. " Staff I explained that it was difficult to provide activities to the men who lived at Apple due to things such as taking Residents served to medical appointments, providing one-on-one coverage for one man, covering for staff lunch times and breaks and for responding to the ever changing behavioral support needs of the men who lived there. At 7:52 AM. Staff I confirmed Resident #11 was still in bed. According to Staff I, since Resident #11 only worked on Monday afternoons, he was allowed to sleep in during the mornings. At 8:12 AM, Staff I confirmed Resident #11 was still in bed. At 8:34 AM, Resident #4 walked into the dining room. He was wearing sweat pants and	W 196		

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W 196	Continued From page 53 had his hands in the waist band of his pants and repeatedly pulled his sweatpants down approximately four inches exposing the disposable brief he wore. He walked around the residence until 8:40 AM at which time Staff I took Resident #11 into the kitchen and assisted him with breakfast. When asked why Resident #11 was eating in the kitchen rather than at the dining room table, Staff I explained that due to the behavior of two non-sampled clients, both of whom exhibited food taking behavior (one of whom was NPO and the other was a " brittle diabetic ") Resident #11 would eat in the kitchen as a safety precaution. Resident #11 completed his breakfast at 8:49 AM and began walking around the residence with his hands on the waist band of his sweat pants. He briefly went outside two times although returned to the residence as soon as he was verbally prompted to do so by staff. The observation was concluded at 9:00 AM. Observation on Wednesday, 1/14/15: 8:50 AM to 12:00 PM Observation was initiated at 8:50 AM at Apple Cottage. Resident #11 was walking around the residence. He was wearing sweat pants and consistently put his hands in the waistband of his sweat pants causing his disposable brief to show. At 9:26 AM, Resident #11 continued to walk through his house touching various objects. He continued to have his hands in the waistband of his sweat pants. At 10:11 AM, Resident #11 went to the area where his coat was stored and put his coat on. At 10:19 AM, he was prompted by Staff B to take his coat off. He complied with this request although he dropped his coat on the floor rather than returning it to the area where coats were hung. At 10:22 AM, after being prompted to	W 196		

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W 196	Continued From page 54 sit down by Staff B, Resident #11 sat in a living room chair for approximately three minutes rubbing his hands together. At 10:25 AM, Resident #11 walked up beside Staff B and leaned heavily against him placing his head near Staff B ' s shoulder. Staff B responded by saying, " You want me to rub your head? " Although Resident #11 did not respond, Staff B rubbed Resident #11 ' s head for approximately 45 seconds and explained Resident #11 enjoyed having his head rubbed. While Staff B was rubbing Resident #11 ' s head, Resident #11 continued to lean more heavily on Staff B causing him to adjust his stance in order to maintain his balance. After regaining his balance, Staff B prompted Resident #11 to stop leaning so heavily against him " before we both fall down. " Resident #11 continued to walk around the residence until 10:45 AM at which time he was prompted by Staff B to go with him in order to " freshen up. " . At 10:15 AM, Resident #11 returned from the bathroom wearing different clothes. He again began to walk around the residence rubbing his hands together and putting his hands on the waistband of his sweat pants. When the lunch carts arrived from the central kitchen at 11:15 AM, Resident #11 proceeded to the dining room and sat down at the table. Staff J reminded Resident #11 that lunch would begin at 11:30 AM. From 11:15 AM to 11:30 AM, Resident #11 walked around the residence going in and out of the front and back door for short periods of time. While walking around the residence he consistently put his hands on the waistband of his sweat pants exposing his disposable brief. At 11:30 AM, Resident #11 was prompted to wash his hands and provided assistance to wash his hands, retrieve his plate and utensils and to sit at the table and eat lunch. Resident #11 finished	W 196		

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W 196	Continued From page 55 lunch at 11:42 AM and after being verbally and physically prompted to return his dishes to the kitchen and wash his hands, Resident #11 began to walk around the residence. During this three hour and ten minute observation, Resident #11 was not observed to be involved in an active treatment program intended to teach skills or increase independence with the exception of the twelve minute time period when Resident #11 received assistance with lunch tasks, including hand washing. 5:00 PM to 7:00 PM Observation was initiated at 5:00 PM at Apple Cottage. Resident #11 was walking around the residence. He was wearing sweat pants and repeatedly had his hands in the waistband of his sweat pants. Resident #11 was prompted to wash his hands and get his plate and silverware from the kitchen at 5:32 PM by Staff E. At 5:57 PM at the conclusion of his meal, Staff E verbally and physically prompted Resident #11 to take his dirty dishes to the kitchen and wash his hands. He complied with this request. After completing the task, Resident #11 began to walk around the residence. At 6:04 PM, Resident #11 had his sweat pants pulled down to reveal his buttocks. He walked through the residence until 6:08 PM with his buttocks exposed until noticed by Staff O who prompted him verbally and physically to go to the bathroom. Resident #11 returned to the dining room at 6:10 PM and proceeded to leave the residence through the back door. The Administrator, who was visiting the cottage, went outside and returned to the inside of the residence at 6:12 PM with Resident #11. Resident #11 continued to walk around the residence sometimes pulling on his disposable brief and/or pulling at the waistband of his sweat pants. At 6:25 PM, Resident #11 pulled his sweat	W 196		

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W 196	Continued From page 56	W 196		

pants down to the floor and stood in the hallway adjoining the dining room until prompted by staff to go to the bathroom. From 6:29 PM to 7:00 PM, Resident #11 was observed walking around the residence looking out the windows, touching objects and/or pulling on the waistband of his sweat pants. During this two hour observation, Resident #11 was not observed to be involved in an active treatment program intended to teach skills or increase independence with the exception of the twenty five minute time period when Resident #11 received assistance with tasks associated with eating his evening meal. The Habilitation Plan Administrator, who serves as the QIDP for Resident #11, was interviewed at 11:00 AM on 01/15/15 with Resident #11 ' s record available for reference. The QIDP confirmed the current IHP for Resident #11 was held on 04/07/14 and included two objectives on which data were maintained. The QIDP said the first objective related to turning off the light when leaving the bathroom. The QIDP said the second objective related to taking his dishes to the sink after mealtime. When told of the observations of Resident #11 spending long periods of time walking around the residence pulling on the waistband of his sweat pants and pulling down his sweat pants, the QIDP confirmed " [Name of Resident #11] likes to walk around. " When asked if the team had identified, through the assessment process, the types of on-campus and off-campus activities Resident #4 enjoyed, the QIDP said Resident #11 enjoyed going on community re-cycling trips, and explained that Resident #11 was scheduled to participate once per week on Monday afternoons. When asked how Resident #11 ' s day was typically spent after completing his daily meals, after turning off the light once he was finished in the bathroom, and

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W 196	Continued From page 57 after participating in the Monday afternoon re-cycling trip, the QIDP said Resident #11 was involved in wide variety of on-campus and off-campus activities. When told of the observations described above, the QIDP said staff were supposed to continually offer Resident #11 a variety of activities in which to participate. The QIDP confirmed there was no expectation of staff to document the nature of the activities offered to Resident #11 and/or his response to the offer to participate in activities. When asked if the team discussed ways to assure Resident #11 received a consistently implemented individualized active treatment program based on assessed skills, interest and preferred activities designed to teach skills and/or lessen the likelihood of Resident #11 losing skills; the QIDP said Resident #11 ' s plan included many training opportunities which were taught on an informal basis. When asked if the IHP for Resident #11 included strategies to teach Resident #11 skills associated with protecting his privacy by not exposing his disposable brief and/or pulling his pants down to expose his buttocks, the QIDP said, "No." Record Review for Resident #11 was conducted on 01/16/15 at 7:30 AM. Resident #11 ' s record included an IHP, dated 4/7/2014. The " Social Needs " section of his IHP included the following information, " ...On campus, [Resident #11] is known by many. He attends community outings and activities around campus. He has no positive peer relationship. He does appear to enjoy staff attention. Should [Resident #11] ever move to a community placement, activities would have to be planned and structured for him. " The " Day Program " section of the IHP documented, " [Resident #11] was assigned to room #3, but due to an increase in aggression, fecal smearing and	W 196		

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W 196	Continued From page 58 other behaviors, it was decided that he did not like being in that area, and after several trials in other rooms in AP without a decrease in inappropriate behaviors, was retired in [redacted] 2008. In [redacted] of 2009, he was again assigned to recycling on Tuesday and Thursdays, but behaviors continued in the classroom, and he was only attending Tuesdays to participate in the town recycle run, where he would frequently be incontinent before he returned to Lakeland. He again took a break from AP recycling runs and primarily participated in cottage activities and PDT trips to town. He is currently going to recycling trips one day weekly with AP, and appears to enjoy this activity." 3. Resident #9: Observation on Monday 1/12/15: 3:55 PM to 4:23 PM: The observation at Pinewood Cottage revealed Resident #9 was in the living room area of the cottage sitting in an easy chair with his legs over the arm of the chair and his back resting against the other arm of the chair. He held a stocking cap and flipped it back and forth in front of his face. At 4:05 PM a staff put on protective gloves and took Resident #9 to the bedroom. At 4:08 PM Resident #9 was out of the bedroom and stood in the hallway and chewed on the stocking cap. A couple of minutes later, he went back and sat down in the chair. At 4:12 PM a staff started talking to him and he got up and walked a bit. The staff said, " Okay, I ' ll leave you alone ". He went back and sat down in the chair. At 4:20 PM a staff gave him a Sesame Street Remote Control toy. At 4:22 PM the staff left and a minute later he threw the toy on the floor. The observation ended. During this 28 minute observation, Resident #9 was not observed to be	W 196		

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W 196	Continued From page 59 involved in an active treatment program intended to teach skills or increase independence. Observation on Tuesday 1/13/15: 4:49 PM to 5:55 PM: The observation at Pinewood Cottage revealed Resident #9 was sitting in the same easy chair from the observation on the previous day. A staff was reading a story from a book, but Resident #9 did not appear to be listening. At 4:58 PM the staff stopped reading the story. At 5:03 PM Resident #9 was still in the chair and was banging a stuffed animal toy against his head. At 5:15 PM Resident #9 was still in the chair. The TV was on but he was facing away from the TV. At 5:30 PM the staff took the dinner items out of the oven. At 5:51 PM all other Residents at the cottage were seated at the dining room table eating dinner, but Resident #9 remained seated in the chair in the living room. At 5:55 PM a staff attempted to get him to come in for dinner, but he headed down the hallway away from the dining room. The staff went after him and encouraged him to go into the dining room, but he veered away from the dining room and went back to sit in the easy chair. During this 66 minute observation, Resident #9 was not observed to be involved in an active treatment program intended to teach skills or increase independence. Observation on 1/14/15: 11:00 AM to 12:00 PM The observation at Pinewood Cottage revealed Resident #9 was in the living room area of the cottage sitting in a chair chewing on a stocking cap. At 11:07 AM a staff took him to the bedroom. At 11:10 AM Resident #9 came out of the bedroom and stood in the hallway and chewed on the cap before eventually going back to the chair in the living room. Staff were beginning to prepare for lunch. At 11:25 AM	W 196		

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W 196	Continued From page 60 Resident #9 got up from the chair and walked into the hallway while chewing on the cap. At 11:28 AM he walked through the kitchen and staff attempted to get him to wash his hands at the kitchen sink, but he did not do so. Staff then had him, through a hand-over-hand method, get a basket containing his place setting for the lunch meal and take it to the dining room table. The staff then took his cap. He did not do anything with the basket containing the place setting. He drank from another Resident ' s glass. Staff put a bib on him and asked if he wanted some spinach. The staff served him the spinach even though there was no indication from Resident #9 that he wanted the spinach. He banged his head on the table. Staff said " [Resident #9 ' s firsts name] " . Later he hit his face with the knuckles of his hand. At 11:39 Resident #9 left the dining room. A staff attempted to get him to come back, but was unsuccessful and then took his bib off. At 11:53 a staff attempted to get him up to eat, but he avoided the dining room and went back to the chair. Observation ended at 12:00 PM. Observation on 1/15/15: 2:10 PM to 2:35 PM at ATP At 2:10 PM in Room 12 of the Adult Training Program area, Resident #9 was observed lying down on a swinging love seat chewing on a cap. Staff assisted him up and he went into the adjoining room briefly. At 2:23 PM Staff R indicated that Resident #9 has had lots of Self-Injurious Behavior (SIB) so they try to keep the area calm and soft. They do massages and use scents to help with the ambiance. At 2:25 Staff R put on gloves and attempted to massage Resident #9 with lavender scented cream but he got up and went into the adjoining room. A short time later he came back hitting his head with a	W 196		

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W 196	Continued From page 61 stuffed toy and sat in a chair. The observation ended at 2:35 PM. During this time Resident #9 was not observed to be involved in an active treatment program intended to teach skills or increase independence. Resident #9 ' s record was reviewed on 1/19/15 at 11:15 AM. His IHP was dated 6/17/14 and contained 3 training programs: to touch the faucet, to grasp the silverware drawer handle before meals, and to press and adaptive switch to turn on a lighted fan. Staff were also tracking incidents of SIB. The goal related to SIB was: " [Resident #9 ' s first name] will decrease episodes of self-abuse to 0 for 12 consecutive months " . The IHP stated his primary need as: " [Resident # 9 ' s first name] ' s primary need is to increase his tolerance for primary care/training to reduce tactile defensiveness " . On 1/21/15 members of Resident #9 ' s Interdisciplinary Team (IDT) were interviewed including the QIDP, Psychology Associate, Nurse, Attendant Counselor Manager, Attendant Counselor 3 for the day shift and the Adult Training Program Supervisor. The IDT acknowledged the IHP stated Resident #9 ' s primary need had been identified as to reduce his tactile defensiveness. The IDT acknowledged Resident #9 had 3 training programs which required him to touch, grasp, and press things. The IDT also acknowledged there was no formal program or methodology instructing staff in how they were to assist Resident #9 to accomplish his training objectives while taking into account his primary need of tactile defensiveness. The IDT also acknowledged that data indicated Resident #9 had no recorded incidents of SIB from July, 2014 through December, 2014, but nothing had	W 196		

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W 196	Continued From page 62 been done to change the program.	W 196		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to functionally assess current daily living skills and identify prioritized needs to be addressed in the individual plan for two of twelve Residents (Residents #4 and #11). This failure placed Residents #4 and #11 at risk of not having their training needs met. Findings Include: Resident #4: During observation on Apple cottage from 10:50 AM to 12:20 PM on 1/12/15, Resident #4 was not observed to be consistently involved in an active treatment program intended to teach skills and increase independence, other than support received at mealtime. During observation on Apple cottage from 3:25 PM to 4:45 PM on 1/12/15, Resident #4 was not observed to be consistently involved in an active treatment program intended to teach skills and increase independence. During observation on Apple cottage from 6:30 AM to 9:00 AM on 1/13/15, Resident #4 was not observed to be involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 8:50 AM to 12:00 PM on 1/13/15, Resident #4 was not observed to be involved in an active treatment program intended to teach skills or increase independence, other	W 214		

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W 214	Continued From page 63 than support received at mealtime and during a four minute period of time when a walking program was initiated. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4, was interviewed at 11:25 AM on 01/15/15 with Resident #4 ' s record available for reference. The QIDP explained the facility used a compilation of assessments from various staff which, when viewed as a whole, was considered the comprehensive functional assessment (CFA). The QIDP confirmed the current Individual Habilitation Plan (IHP) for Resident #4 was held on 08/07/14 and included three objectives on which data were maintained. The QIDP said the objectives related to scooping food from a serving bowl, hair washing, and reducing the frequency of aggression. The QIDP confirmed although the team was aware of the various needs identified through the assessment process, the needs were not prioritized in order to determine what objectives were included in the IHP. The QIDP explained that rather than prioritizing the needs based of assessment, team members suggested possible objectives which were either accepted or rejected by the team. When asked if the team identified, through the assessment process, the types of on-campus and off-campus activities Resident #4 enjoyed, the QIDP said there was a section in the IHP which addressed that. When asked if the team for Resident #4 had created an individualized active treatment program predicated on assessed skills, interest and preferred activities designed to teach skills and/or lessen the likelihood of Resident #4 losing skills, the QIDP said Resident #4 ' s plan was not that specific. When asked about the team ' s expectation for participation in preferred activities beyond the formalized objectives related	W 214		

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W 214	Continued From page 64 to scooping food, personal hygiene and reducing aggression, the QIDP explained other activities were done on an " informal basis " when opportunities were presented. The QIDP confirmed there was no documented evidence of the frequency or type of activities offered to Resident #4 beyond assuring he had access to the car magazines. Resident #4 ' s record included an IHP, dated 8/7/14. The " Social Needs " section of his IHP documented, " When in the mood, [Name of Resident #4] enjoys activities including going to dances, going for walks, watching television and VCR tapes (e.g., the Wiggles series). He likes to interact with staff and will greet people as they come to his home. [Resident #4] likes praise and enjoys a good joke. He likes carrying copies of the Wheels Deals magazines and finds Volkswagen bugs if requested. " The " Day Program " section of the IHP documented, " [Resident #4] used to attend the recycling center at Adult Programs, however due to continual refusals and assaultive behaviors when he did go, Adult Programs were discontinued on 04/26/06. Direct Care staff continue to offer him the opportunity to go to the Adult Training area when his peers are going to work, and at times he will be agreeable and go with them. If [Resident #4] begins to show a consistent interest in participating in Adult Training activities, a referral will be sent to that area for assessment. " During observation on Apple cottage from 10:50 AM to 12:20 PM on 1/12/15, Resident #11 was not observed to be consistently involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 3:25 PM to 4:45 PM on	W 214		

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W 214	Continued From page 65 1/12/15, Resident #11 was not observed to be consistently involved in an active treatment program intended to teach skills and increase independence. During observation on Apple cottage from 6:30 AM to 9:00 AM on 1/13/15, Resident #11 was not observed to be involved in an active treatment program intended to teach skills and increase independence, other than support received at mealtime. During observation on Apple cottage from 8:50 AM to 12:00 PM on 1/13/15, Resident #11 was not observed to be involved in an active treatment program intended to teach skills and increase independence, other than support received at mealtime. The Habilitation Plan Administrator, who serves as the QIDP for Resident #11, was interviewed at 11:00 AM on 01/15/15 with Resident #11 's record available for reference. The QIDP explained the facility used a compilation of assessments from various staff which, when viewed as a whole, was considered the CFA. The QIDP confirmed the current IHP for Resident #11 was held on 04/07/14 and included two objectives on which data were maintained. The QIDP said the objectives related to turning off the light when leaving the bathroom and taking dishes to the sink after mealtime. The QIDP confirmed although the team was aware of the various needs identified through the assessment process, the needs were not prioritized in order to determine what objectives were included in the IHP. The QIDP explained that rather than prioritizing the needs based on assessment, team members suggested possible objectives which were either accepted or rejected by the team. When told of the observations of Resident #11 spending long periods of time walking around the residence pulling on the waistband of his sweat pants and pulling down his sweat pants exposing	W 214		

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W 214	Continued From page 66 his disposable brief, the QIDP confirmed " [Name of Resident #11] likes to walk around." The QIDP confirmed the team had not assessed the function of the behavior of pulling at the waistband of his pants and pulling down his pants in common areas and had not identified this as a prioritized need. When asked if the team had identified, through the assessment process, the types of on-campus and off-campus activities Resident #11 enjoyed, the QIDP said Resident #11 enjoyed going on community re-cycling trips, and was scheduled to participate once per week on Monday afternoons. When asked how Resident #11 ' s day was supposed to be spent after completing his daily meals, after turning off the light when finished in the bathroom, and after participating in the Monday afternoon re-cycling trip, the QIDP said he was involved in wide variety of on-campus and off-campus activities. When told of the observations described in detail under W196, the QIDP said staff were supposed to continually offer Resident #11 a variety of activities in which to participate. The QIDP confirmed there was no expectation of staff to document the nature of the activities offered to Resident #11 and his response to offered activities. When asked if the team had discussed ways to assure Resident #11 received a consistently implemented individualized active treatment program based on assessed skills, interest and preferred activities designed to teach skills and/or lessen the likelihood of Resident #11 losing skills, the QIDP said Resident #11 ' s plan included many training opportunities which were taught on an informal basis. The QIDP was asked if the IHP for Resident #11 included strategies to teach Resident #11 skills associated with protecting his privacy by not having his hands in the waistband of his sweat pants	W 214		

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W 214	Continued From page 67 resulted in exposing his disposable brief and/or pulling his pants down to expose his buttocks, the QIDP said no strategies had been developed. Record Review for Resident #11 was conducted on 01/16/15 at 7:30 AM. Resident #11 ' s record included an IHP, dated 4/7/2014. The " Social Needs " section of his IHP included the following information, " ...On campus, [Resident #11] is known by many. He attends community outings and activities around campus. He has no positive peer relationship. He does appear to enjoy staff attention. Should [Resident #11] ever move to a community placement, activities would have to be planned and structured for him. " The " Day Program " section of the IHP documented, " [Resident #11] was assigned to room #3, but due to an increase in aggression, fecal smearing and other behaviors, it was decided that he did not like being in that area, and after several trials in other rooms in AP without a decrease in inappropriate behaviors, was retired in August 2008. In January of 2009, he was again assigned to recycling on Tuesday and Thursdays, but behaviors continued in the classroom, and he was only attending Tuesdays to participate in the town recycle run, where he would frequently be incontinent before he returned to Lakeland. He again took a break from AP recycling runs and primarily participated in cottage activities and PDT trips to town. He is currently going to recycling trips one day weekly with AP, and appears to enjoy this activity. "	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227		

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W 227	Continued From page 68 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop objectives to address behaviors for 2 of 12 sampled Residents (Resident #11 and Resident #9). This failure impacted the Residents ability to function in daily life by not having appropriate interventions developed to meet their needs and address their behavior. Findings Include: 1. Observation was initiated at 10:50 AM on 01/12/15 at Apple Cottage. Throughout the observation, with the exception of when Resident #11 was assisted with lunch between 11:32 AM - 11:46 AM, Resident #11 walked around the residence going from the living room, through the dining room, sometimes into his bedroom for a brief period of time, then down the hallway and through the living room. He was wearing sweat pants and often placed his hands on the waistband of his sweat pants pulling them down to expose the disposable brief he wore. At 11:46 AM, at the conclusion of Resident #11 ' s lunch, as he was walking through the residence, Resident #11 grabbed food from the plate of a non-sampled Resident. He was immediately redirected by Staff L and did not ingest the food. Observation was initiated at 6:30 AM on 01/13/15 at Apple Cottage. At 8:12, Staff I confirmed Resident #11 was still in bed. At 8:34 AM, Resident #11 walked into the dining room. He was wearing sweat pants and had his hands in the waist band of his pants and repeatedly pulled his sweatpants down approximately four inches exposing the disposable brief he wore. He walked around the residence until 8:40 AM at	W 227		

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W 227	Continued From page 69 which time he was assisted with breakfast. Resident #11 completed his breakfast at 8:49 AM and began walking around the residence with his hands in the waistband of his sweat pants exposing his disposable brief. Observation was initiated at 8:50 AM on 01/13/15 at Apple Cottage. Client #11 was walking around the residence. He was wearing sweat pants and he consistently put his hands in the waistband of his sweat pants causing his disposable brief to show. From 9:26 AM to 10:45 AM, Resident #11 continued to walk through the residence with his hands in the waistband of his sweat pants. At 10:45 AM Resident #11 was prompted by Staff B to go with him in order to " freshen up. " At 10:50 AM, Resident #11 returned from the bathroom wearing different clothes. From 10:50 AM to 11:30 AM, Resident #11 walked around the residence putting his hands on the waistband of his sweat pants exposing his disposable brief. Observation was initiated at 5:00 PM on 01/14/15 at Apple Cottage. Resident #11 was walking around the residence. He was wearing sweat pants and repeatedly had his hands in the waistband of his sweat pants. Resident #11 was provided mealtime supports from 5:32 PM to 5:57 PM. After finishing his meal, Resident #11 began to walk around the residence. At 6:04 PM, Resident #11 pulled his sweat pants down to reveal his buttocks. He walked through the residence until 6:08 PM with his buttocks exposed until noticed by Staff O who verbally and physically prompted him to go to the bathroom. Resident #11 returned to the dining room of his residence at 6:10 PM and went outside for two minutes. Resident #11 returned to the inside of the residence at 6:12 PM and continued to walk around the residence sometimes pulling on his disposable brief and/or pulling at the waistband of	W 227		

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W 227	Continued From page 70 his sweat pants. At 6:25 PM, Resident #11 pulled his sweat pants down to the floor and stood in the hallway adjoining the dining room until prompted by staff to go to the bathroom. From 6:29 PM to 7:00 PM, Resident #11 was observed walking around the residence pulling on the waistband of his sweat pants exposing his disposable brief. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disabilities Professional (QIDP) for Resident #11, was interviewed at 11:00 AM on 01/15/15 with Resident #11 ' s record available for reference. The QIDP confirmed the current Individual Habilitation Plan (IHP) for Resident #11 was held on 04/07/14 and included two objectives on which data were maintained. The QIDP said the first objective related to turning off the light when leaving the bathroom. The QIDP said the second objective related to taking his dishes to the sink after mealtime. The QIDP confirmed Resident #11 ' s IHP did not address the observed behaviors of exposing his disposable brief, pulling down his pants in common areas and/or food taking behavior. Record Review for Resident #11 was conducted on 01/16/15 at 7:30 AM. Resident #11 ' s record included an IHP, dated 4/7/2014. The IHP did not address the behaviors of exposing his disposable brief, pulling down his pants in common areas and food taking behavior. Resident #11 ' s record included a document titled; " Functional Assessment and Behavior Support Plan " (BSP). The BSP did not address the behaviors of exposing his disposable brief, pulling down his pants in common areas and/or food taking behavior. Resident #9 2. While observing Resident #9 in the Adult Training Program on 1/15/15 2:10 PM, Staff R	W 227		

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W 227	Continued From page 71 revealed Resident #9 had problems with tactile defensiveness and much of what they did in their time with Resident #9 was designed to help him accept touch and to touch things. Resident #9 ' s record was reviewed on 1/19/15 at 11:15 AM. His IHP was dated 6/17/14 and it indicated his primary need was: " [Resident # 9 ' s first name] ' s primary need is to increase his tolerance for primary care/training to reduce tactile defensiveness " . Further review of the IHP revealed there was no objective to formally address his tactile defensiveness. The QIDP (Staff II) acknowledged there was no formal program related to his primary need of tactile defensiveness.	W 227		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop written instructions to staff about the use of a gait belt, a wheelchair and the implementation of a walking program for one of one sampled residents (Resident #4) recovering from a fracture. This failure prevented Resident #4 from receiving necessary supports and services toward functioning at a more independent level. Findings Include: Observation was initiated at 10:50 AM on 01/12/15 at Apple Cottage. Resident #4 was lying on a mat in the living room of his residence. He was wearing a gait belt positioned about two inches below his breasts. At 11:36 AM Staff B	W 240		

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W 240	Continued From page 72 and Staff C transferred Resident #4 to a wheelchair and assisted him to the dining room for lunch. The gait belt was not used during this transfer. At 11:53 AM, Resident #4 was transferred from his wheelchair to the mat by staff Staff B and Staff H in the living room. The gait belt was not used during this transfer. The gait belt was not removed once Resident #4 was transferred to the mat. Observation was initiated at 3:25 PM on 01/12/15 at Apple Cottage. Resident #4 was seated in a recliner with his feet elevated. Resident #4 was wearing a gait belt which was positioned approximately two inches below his breasts. At 3:38 PM, Staff F assisted Staff E to transfer Resident #4 to a wheelchair. The gait belt was not used during the transfer nor was it removed once Resident #4 was seated in his wheelchair. At 3:44 PM, Staff E and Staff G, transferred Resident #4 to a recliner. The gait belt was not used during the transfer nor was it removed once Resident #4 was seated in the recliner. Observation was initiated at 6:30 AM on 01/13/15 at Apple Cottage. At 8:21 AM, Resident #4, seated in his wheelchair, was brought into the dining room by Staff B. Resident #4 was wearing a gait belt positioned approximately three inches below his breasts. Staff B assisted Resident #4 to transfer to a dining room chair at 8:24 AM. The gait belt was not used during the transfer nor was it removed or adjusted when Resident #4 was seated in the dining room chair. At 8:33 AM, Staff B and Staff I, transferred Resident #4 from the dining room chair to his wheelchair, pushed Resident #4 in his wheelchair in the living room and at 8:35 AM transferred Resident #4 from his wheelchair to a recliner. The gait belt was not used during the transfer nor was the gait belt removed once Resident #4 was seated in the	W 240		

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W 240	Continued From page 73 recliner. Observation was initiated at 8:50 AM on 01/13/15 at Apple Cottage. Resident #4 was seated in a recliner in the living room. He was wearing a gait belt positioned approximately two inches below his breasts. At 9:01 AM, Resident #4 dropped on his knees in front of the recliner and crawled from the recliner to the corner of the room and laid down. At 9:14 AM, Staff B and Staff C transferred Resident #4 into his wheelchair then to a recliner. The gait belt was not used during the transfers and was not removed once Resident #4 was seated in the recliner. At 9:26 AM, Resident #4 appeared to be asleep sitting in the recliner with his feet elevated and the gait belt on. Staff C confirmed he had not received training related to the use of the gait belt worn by Resident #4. Staff C said he was unaware of any written instruction about the use of the gait belt. Staff C said he did not know when the wheelchair was to be used and when Resident #4 was to be encouraged to walk with assistance. At 10:16 AM, Staff J, approached Resident #4 and asked if he wanted " to take a walk." Staff J and Staff B helped Resident #4 stand up. Both staff assisted Resident #4 to walk approximately 30 feet prior to transferring him back into his wheelchair at 10:20 AM. The gait belt was used to assist Resident #4 while walking. At 10:28 AM, Resident #4 was transferred back to the recliner. He continued to wear the gait belt. At 10:29 AM, Staff J said she was unaware of any written instructions for staff about the use of the gait belt and/or the wheelchair. Staff J confirmed there were no written instructions to staff about how often or the distance Resident #4 should be walking. Staff J confirmed there was no written plan on how to assist Resident #4 to walk more and rely less on the wheelchair.	W 240		

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W 240	Continued From page 74 Resident #4 remained seated in the recliner until 11:30 AM, at which time Staff B and Staff J transferred him to his wheelchair and assisted him to the dining room for lunch to transfer to a dining room chair. The gait belt was not used in either transfer. Resident #4 finished lunch at 11:48 AM at which time he was transferred from the dining room chair to his wheelchair and from his wheelchair to the recliner. The gait belt was not used during either transfer. At 12:00 PM, when the observation ended, Resident #4 appeared to be asleep sitting in the recliner wearing the gait belt which was positioned approximately three inches below his breasts. Observation was initiated at 5:00 PM on 01/14/15 at Apple Cottage. Resident #4 was lying on a mat on the floor directly under the wall mounted television in the living room. Resident #4 appeared to be asleep and had a blanket over his head. At 5:57 PM, Resident #4 was transferred to his wheelchair by Staff K and Staff E. Although Resident #4 was wearing a gait belt, it was not used during the transfer. At the conclusion of his evening meal at 6:20 PM, Resident #4 was transferred from the dining room chair to his wheelchair and then to his recliner by AC1- Staff K and Staff E. The gait belt was not used during the transfer. From 6:20 PM to 6:35 PM, Resident #4 sat in the recliner with his head down. He was wearing the gait belt. At 6:35 PM, Resident #4 appeared to be asleep sitting in his recliner and remained that way until 7:00 PM at the time the observation was concluded. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4, was interviewed at 11:25 AM on 01/15/15 with Resident #4 ' s record available for reference. The QIDP explained on 08/31/14, Resident #4 fell from a toilet seat and	W 240		

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W 240	Continued From page 75 sustained a fracture. According to the QIDP, Resident #4 ' s fracture was surgically repaired and he remained in the community hospital until 09/05/14. The QIDP confirmed once returned to his residence, Resident #4 participated in Physical Therapy. The QIDP confirmed although Resident #4 no longer received " direct " physical therapy, this IHP had not been amended to include instructions to staff about the " at home " walking program. The QIDP confirmed that although a gait belt and a wheelchair were being used with Resident #4 during his recovery from the fracture, the IHP had not been amended to include written instruction to staff about the use of the wheelchair and/or the use of the gait belt. Record Review for Resident #4 was conducted on 01/16/15 at 6:30 AM. Resident #4 ' s record included an email dated, 12/22/14, to the QIDP from a Physical Therapist documenting Resident #4 would be discontinued from physical therapy services. The email included a recommendation which documented, " I recommend that staff continue to walk with [Name of Resident #4] using a gait belt and two hands held with one staff following with wheelchair for mobility on the cottage. " The record for Resident #4 did not include written instructions to staff about the use of the gait belt and/or the wheelchair. The record for Resident #4 did not include written instructions to staff about implementing the walking program.	W 240		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication	W 242		

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W 242	Continued From page 76 of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to include training programs in basic skills areas for 1 of 12 Sampled Residents (Resident #9). Resident #9 lacked skills in toileting and there was no formal training program to address this need. This failure placed Resident #9 at risk of not developing basic skills to increase his independence. Findings include: Observations of Resident #9 on 1/12/15 at 4:05 PM, on 1/14/15 at 11:07 AM revealed staff put on protective gloves and took Resident #9 into his bedroom to change his adult protective garment. Review on 1/19/15 of Resident #9 ' s IHP dated 6/17/14 revealed " On occasion [Resident #9 ' s first name] will use the toilet appropriately if staff member is within close proximity of him. For the most part though, he shows incontinence " . There was no formal training program related to the skill of toileting independently. Interview on 1/20/15 with Resident #9 ' s Interdisciplinary Team verified Resident #9 was not independent in toileting and there was no formal training program for Resident #9 related to toileting skills.	W 242		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247		

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W 247	Continued From page 77 This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to create situations for seven Residents (Residents #1, #3, #5, #6, #27, #37, and #38) which promoted Residents in their ability to manage their daily routines. The facility adhered to a strict meal time frequently resulting in Residents sitting at the table for extended periods of time waiting for the meal and not encouraging Residents to help prepare their food. In another situation, the facility developed programs which forced a Resident to make choices of what to eat according to the facility's parameters. These failures prevented Residents from being encouraged to manage their daily lives. Findings include: 1. Observation on 1/13/15 of the dinner meal at Pinewood revealed staff did not start serving food until 5:30 PM even though Residents were at the dining room table well before this time. Observation on 1/14/15 of the lunch meal at Pinewood revealed staff assisted Residents to come to the table starting at approximately 11:15 AM, however the food was not served until 11:30 AM. Observation on 1/14/15 of the dinner meal at Bigfoot Cottage revealed Resident #6 was encouraged to get his dishes onto the table for dinner. Several Residents were already sitting at the dining room table. Staff started assisting Residents with serving the food at 5:30 PM. Observation on 1/15/15 of the lunch meal at Bigfoot revealed at 11:25 AM Resident #6 was sitting at the dining room table ready to eat. Serving the food did not start until 11:30 AM. Interview on 1/20/15 at 10:33 AM with the QIDP for Resident #6 verified the facility adheres to strict meal times of 11:30 AM for lunch and 5:30 PM for dinner. He stated this was to give	W 247		

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W 247	Continued From page 78 Residents a chance for socialization and to do family style dining. 2. Observation of Resident #1 on 1/12/15 at 11:05 AM at Cascade Cottage revealed he was in his bedroom playing video games. At 11:15 AM Resident #1 came out of his bedroom and began making his own lunch. Review on 1/19/15 of Resident #1 ' s record revealed his Resident Habilitation Plan (IHP) was dated 12/12/14. It contained the following objectives: " D.06 [Resident #1 " s first name] will maintain the skill of waiting until dinner is on the counter before making his choice for dinner " , and it included the following justification - " [Resident #1 ' s first name] has a habit of choosing what he wants to eat before looking at the dinner menu. This behavior leads to anxiety when asked by staff to try the food provided. " ; D.17 [Resident #1 ' s first name] will wait until lunch is on the counter before making his choice for lunch " , and it included the same justification as for D.06; D.13 [Resident #1 ' s first name] will maintain waiting until breakfast is on the counter before making his choice for breakfast " , and it included the same justification as for D.06. Interview on 1/20/15 at 1:40 PM with Staff CC, the QIDP for Resident #1, verified the objectives were part of Resident #1 ' s IHP. She stated the objectives were designed to have Resident #1 make an " informed choice " Instead of an emotional one. 3. Observation of Sunrise on 1/13/2015 at 4:00 PM revealed the dinner meal arrived on the house at 4:25 PM. At 5:15 PM, Staff SS is observed preparing the dinner meal and alternative food choices. Resident #37 repeatedly entered the kitchen area as Staff SS prepared the meal. Staff SS redirected and escorted Resident #37 out of the kitchen back to his chair at the dining room table to wait for the dinner meal. At	W 247		

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W 247	Continued From page 79 5:30 PM, Resident #37 threw his chair to the floor. Staff were observed consoling Resident #37 and other residents on Sunrise impacted by Resident #37 ' s behavioral outburst. At 5:40 PM Resident #37 received a sandwich which he quickly consumed. Staff SS acknowledged " sometimes it ' s hard to wait " . Interview with Staff TT on 1/21/2015 at 1:30 PM acknowledged meals are served at 7:30 AM (breakfast), 11:30 AM (lunch) and 5:30 PM for dinner. Staff TT stated we have to " wing it " if behaviors increase while Residents are waiting for the meal. Staff TT acknowledged she redirects residents prior to the assigned meal times and informs them they will have to wait. 4. Observation of Hillside on 1/14/2015 at 5:00 PM and 1/15/2015 at 5:30 PM revealed Resident # 5 was seated at the dining room table waiting for the meal to be served. Staff UU acknowledged meal time were set at 7:30 AM for breakfast, 11:30 AM for lunch and 5:30 PM for dinner. 5. On 1/20/2015 at 1:10 PM, following an incident involving Resident #38 that had occurred prior to lunch, Staff VV was interviewed about the incident. Staff VV verified Resident #38 had been playing a Wii Game. Staff VV reported he had approached Resident #38, who is hearing impaired, to inform him that it was lunch time. Staff VV stated Resident #38 pointed to the Wii Game on the TV screen and Staff VV believed Resident #38 wanted the Wii game turned off. Staff VV acknowledged he turned off the Wii game and that Resident #38 had a behavioral incident when the game was turned off. Staff VV reported he tries to adhere to meal times. 6. Observation at 77 Willow cottage at 5:05 PM on 1/13/15 revealed Staff Z brought food from the 76 side of the cottage in a brown thermal box.	W 247		

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W 247	Continued From page 80 The food was placed in the oven. Residents were instructed to get their silverware and plates and set the items on the table. Residents started gathering in the kitchen/dining area of the home. Resident #3 sat and watched TV. Resident #27 sat at the dining room table. At 5:30 PM the food was taken out of the oven by staff, temped by staff and placed in serving bowls by staff. Staff brought the food to the table. Interview with Staff Z revealed residents cannot eat until 5:30 PM. 7. Observation at 77 Willow cottage at 5:05 on 1/13/15 revealed staff brought food from the 76 side of the cottage in a brown thermal box. The food was placed in the oven. At 5:30 PM the food was taken out of the oven, temped by staff and placed in serving bowls. Staff instructed Residents to serve themselves. Residents #27 and #3 did not assist in the preparation of the meal. Resident #27 was interviewed on 1/14/15 about his abilities to cook a meal. Resident #27 revealed he knew how to cook chicken adding that the chicken was done when it was no longer pink inside. Review of Resident #3's IHP dated 9/10/14 revealed he can prepare his own lunch for work with supervision. Interview with Resident #3 on 1/19/15 revealed he does not cook because the "fire marshal will be mad." 8. Observation 1/12/15 at 77 Willow Cottage at 11:30 AM revealed Resident #3 was asked to get some bread to make a sandwich. Resident #3 told staff his knee hurt. Staff proceeded to get the bread for Resident #3. Later Resident #3 was observed walking about the campus without difficulty.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 81 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure individual program plans were consistently implemented for 3 of 12 sampled residents (Resident #3, #4, and #7) sampled residents. This failure prevented the residents from having an opportunity to learn skill development and work toward accomplishing their objectives. Findings Include: 1. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4, was interviewed at 11:25 AM on 01/15/15 with Resident #4 ' s record available for reference. The QIDP confirmed the current Individual Habilitation Plan (IHP) for Resident #4 was held on 08/07/14 and included three objectives on which data were maintained. The QIDP confirmed Resident #4 IHP included " Non-Programed Services " which included the expectation that Resident #4 would participate in at least three community integration activities per month. The QIDP said due to many factors, including disinterest in activities presented, Resident #4 had not participated in three community-based activities since October 2014	W 249		

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W 249	Continued From page 82 although he was medically able to participate. Record Review for Resident #4 was conducted on 01/16/15 at 6:30 AM. During the interview with the QIDP on 1/5/15, a copy of a document titled " Monthly Progress Report of the Individual Habilitation Plan " (Monthly Review) was provided for review. Although the document was not dated, when presented for review, the QIDP identified the document as the " most current " review of Resident #4 ' s IHP and included review of December 2014 data. The Section of the report titled, " Non-Programmed Services " documented, " [Resident #4 will have the opportunity to participate in at least three community integration activities per month. Integration activities will be reported monthly ... " The documentation included by the QIDP in the Monthly Review stated, " For the reporting period from September 8th to October 8th [2014] [Resident #4] had not participated in Community Integration due to medical issues. Community Integration from October 8, 2014 to November 8, 2014: [Resident #4] went on a bus ride and shopping. " An entry dated, 1/9/15, documented, " [Resident #4 went on two community integration activities from December 8, 2014, to January 8, 2015. Once to eat out and once to recycle. " 2. Record review of Nursing Orders from 15 Dec - 14 Jan 14 for Resident #7 revealed he was to receive oral care BID and prn and to cleanse groin area twice daily and use antiperspirant. There was no documentation that oral care occurred on the following dates: 12/26/14, 12/28/14, 1/1/15 (pm shift) and no documentation that cleanse groin area twice daily and use antiperspirant on 12/26/14, 12/28/14 1/1/15, 1/6/15 occurred. Interview with Staff ZZ acknowledged it ' s not clear if staff failed to document that care was	W 249		

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W 249	Continued From page 83 received or if Resident #7 refused care. Staff confirmed there is no direction on what to do. 3. Interview with Resident #3 on 1/12/15 revealed he had arthritis in his knee. Record review on of Resident #3's Resident Habilitation Plan dated 9/10/14 revealed he used the following therapeutic equipment: [redacted] knee support item and support socks. Observation of Resident #3 on 1/19/15 revealed he was not wearing the [redacted] knee support item or support socks. Interview with Resident #3 revealed the support socks were too tight. Staff HH revealed neither the [redacted] knee support item or support socks could be found. Interview with Staff AA on 1/27/15 revealed he was unaware Resident #3 did not have the [redacted] knee support item or the support socks.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to develop a schedule designed to direct the daily activities of the staff and the Residents in the implementation of active treatment programs for 3 of 12 sampled Residents (Resident #4, #10, and 11). This failure prevented staff from knowing what to do with the residents. Findings Include: 1. During observation on Apple cottage from 10:50 AM to 12:20 PM on 1/12/15, neither Resident #4 nor Resident #11 was observed to be	W 250		

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W 250	Continued From page 84 consistently involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 3:25 PM to 4:45 PM on 1/12/15, neither Resident #4 nor Resident #11 were observed to be consistently involved in an active treatment program intended to teach skills or increase independence. During observation on Apple cottage from 6:30 AM to 9:00 AM on 1/13/15, neither Resident #4 nor Resident #11 was observed to be involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime. During observation on Apple cottage from 8:50 AM to 12:00 PM on 1/13/15, neither Resident #4 nor Resident #11 were observed to be involved in an active treatment program intended to teach skills or increase independence, other than support received at mealtime and, for Resident #4, a four minute period of time when a walking program was initiated. The Habilitation Plan Administrator, who serves as the Qualified Intellectual Disability Profession (QIDP) for Resident #4 and Resident #11, was interviewed beginning at 11:00 AM on 01/15/15 with the records of Resident #4 and Resident #11 available for reference. The QIDP confirmed the day programming provided on Apple Cottage was very flexible and was often dependent on the immediate behavior support needs of the men who lived there as well as the number of staff available to provide individualized programming. The QIDP confirmed Resident #4 was not involved in a program which included times when he was expected to participate in programming or activities. The QIDP confirmed the only " scheduled " activity for Resident #11 occurred on	W 250		

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W 250	Continued From page 85 Monday afternoon when he was involved in recycling. When asked if the teams for Resident #4 and Resident #11 had developed a schedule intended to provide structure for the provision of active treatment for Resident #4 and Resident #11, the QIDP explained the structure of their programming was fluid and not schedule based. Record Review for Resident #4 was conducted on 01/16/15 at 6:30 AM. Resident #4 ' s record did not include an active treatment schedule. Record Review for Resident #11 was conducted on 01/16/15 at 7:30 AM. Resident #11 ' s record did not include an active treatment schedule. 2. Resident #10 was observed at work on 1/13/15 from 9 AM to 9:15 AM. She sat at a table taping strips of pink paper together. Observation on 1/ 15/15 at 11 AM revealed Resident #10 was at home, in her room. Staff P indicated Resident #10 stayed home from work due to medical condition. When asked what Resident #3 would do now that she is at home and not at work, Staff P stated "whatever she wants." Resident #10 did not come out of her room until lunch time at approximately 11:20 am. Resident #10 was observed gathering her dishes for lunch and assisting to make her sandwich. Observation on 1/19/15 at 3:10 pm and 3:20 revealed Resident #10 was in her room. Staff FFF was asked why resident #10 was in her room, Staff FFF replied he "chooses to stay in her room" and "she can tell you what she wants to do." Interview with Staff CC on 1/20/15 at 1:00 PM revealed resident #10 is "self-directed and that she can choose what she wants to do." Staff C was asked if the staff working with Resident #10 have access to an "active treatment schedule" for Resident #10. Staff C stated no.	W 250		

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W 255	Continued From page 86	W 255		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure revisions were made to the Individual Habilitation Plan for 1 of 12 sampled residents (Resident #9). This failure prevented the resident the opportunity to learn new skills. Findings include: Review on 1/19/15 of Resident #9 ' s IHP dated 6/17/14 revealed it contained the following objective, labeled I.01: " [Resident #9 ' s first name] will decrease episodes of self-abuse to 0 for 12 consecutive months " . A Quarterly Report - Psychology Services for Resident #9 revealed there were no recorded instances of self-abuse from July, 2014 through December, 2014. Interview on 1/20/15 with the Interdisciplinary Team (IDT) for Resident #9, including the QIDP, verified the accuracy of the lack of self-abuse for a 6 month period. The IDT did not explain the rationale for having 12 consecutive months of no recorded instances as opposed to a different criteria that could have been chosen. The IDT acknowledged the lack of instances of the behavior for 6 consecutive months had not resulted in a change to the program.	W 255		
W 290	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 290		

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W 290	Continued From page 87 Standing or as needed programs to control inappropriate behavior are not permitted. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to justify the inclusion of a highly restrictive procedure to manage behavior based on assessed need and frequency of the behavior for 1 of 1 sampled Resident (Resident #11) who wore a " code alert " bracelet. This failure denied the resident the opportunity of being free of a restrictive device. Findings Include: Observation was initiated at 10:50 AM on 01/12/15 at Apple Cottage. Throughout this observation and all subsequent observations during the survey, Resident #11 was observed to be wearing a " code alert " bracelet on his left wrist. The Habilitation Plan Administrator, who serves as the QIDP for Resident #11, was interviewed at 11:00 AM on 01/15/15 with Resident #11 ' s record available for reference. When asked to explain the " code alert " bracelet worn by Resident #11, the QIDP explained the code alert allowed the facility to " locate " Resident #11 in the event he could not be found. The QIDP confirmed the expectation was for Resident #11 to wear the code.alert bracelet at all times. According to the QIDP, a devise with an antenna was maintained at the facility ' s switchboard which could be activated in the even Resident #11 could not be located. According to the QIDP, it would take a few minutes for personnel to set up the equipment in an attempt to activate the antenna to identify the location of the code alert bracelet worn by Resident #11. The QIDP	W 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	01/27/2015

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LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 290	Continued From page 88 confirmed he could not remember the last time the equipment with the antenna was used to locate Resident #11 but said it had been at least two years. The QIDP said he did not know if there was a system in place to routinely check the " code alert system " to assure it worked properly. The QIDP confirmed the team for Resident #11 had not considered the advisability of removing the restrictive device since it had not been used in more than two years. Record Review for Resident #11 was conducted on 01/16/15 at 7:30 AM. Resident #11 ' s record included a document titled, " Functional Assessment and Behavior Support Plan " (BSP), dated 11/25/14. The " Justification " section of the BSP documented, " [Resident #11] does not demonstrate awareness of environmental hazards. He has run toward roads and has left assigned areas not properly dressed for weather conditions. The proposed BSP will not prescribe restrictive interventions other than wearing a code alert bracelet. Because of potential danger of harm, [Resident #11] will wear the code alert bracelet at all times so staff will know when he leaves his cottage unescorted ... " The BSP did not include data regarding the frequency the code alert system was used.	W 290		
W 301	483.450(d)(4) PHYSICAL RESTRAINTS A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to develop a system for staff to monitor Residents who were placed in a toilet positioning	W 301		

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W 301	Continued From page 89 device that was restrictive while sitting on the toilet. This failure placed Residents at risk of potential harm should the Resident need to be released from the restraint immediately. Findings include: Observation on 1/20/15 at 10:00 AM of a bathroom at 70/71 Evergreen Cottage revealed a toilet with a seatback made from a piece of plywood covered with vinyl. Attached to the seatback was a strap with a buckle. Interview with Staff P revealed the "toilet positioning device" was for Resident #17. Staff assisted Resident #17 to use the toilet every two hours. Staff "strap" Resident #17 to the toilet because she has "drop [redacted]3. When asked how often staff check on Resident # 17 once she was placed in the restraint, Staff P stated they "walk back and forth." Staff P added that there was no set time to check Resident #17 but he "thought it was about every ten minutes."	W 301		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure the specially prescribed diet was followed for 1 of 12 sampled residents (Resident #5). This failure to provide specially prescribed diets placed resident at risk of health problems. Findings include: Observation of Hillside Cottage on 1/14/2015 at 5:25 PM (dinner meal) and 1/15/2015 at 11:30	W 460		

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W 460	Continued From page 90 AM (lunch meal) revealed Resident # 5 independently poured milk into her plastic tumbler. Interview with Staff PP confirmed the amount of milk in the tumbler was approximately 12 ounces. Record review of Resident # 5 ' s Diet Orders printed 1/4/2015 revealed she was to receive 1 cup skim milk and 1 cup water at breakfast, lunch and dinner. The Diet Order specified the amount of food/liquids stated must be followed. Interview with Staff YY acknowledged the 8 oz. tumblers were on order and provided a purchase order for 432 Carlisle tumbler, clear, 8 oz. dated 1/12/2015.	W 460		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

October 9, 2013
CERTIFIED MAIL 7007 1490 0003 4201 9768

Diane Kilgore, Acting Superintendent
Lakeland Village
P.O. Box 200
Medical Lake, WA 99022

RE: Recertification Survey 09/09/2013 through 09/13/2013

Dear Ms. Kilgore:

From 09/09/2013 through 09/13/2013 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review); and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	09/13/2013

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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey and Complaint Investigations (2861225/2874630) conducted at Lakeland Village on 09/09/13 through 09/13/13. A sample of 12 residents was selected from a census of 128. The Expanded Sample included current residents. The survey was conducted by: Janette Buchanan, R.N., B.S.N. Terry Patton, R.N., B.S.N. Claudia Baetge, M.A. Christina Borchardt, R.N., B.S.N. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2405 Fax: (360) 725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christina D. Borchardt
TITLE: Superintendent
(X6) DATE: 11/04/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 Based on observations and interviews, the facility failed to ensure staff handled and stored food properly, ensured main kitchen staffs Food Handler cards were current and failed to ensure a hazard free environment. These failures placed residents at risk of harm for potential of food borne illness and at risk of potential tripping hazards and entrapment. Findings include: All observations, record reviews and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Refrigerators and freezers in Main kitchen 1. Half-gallon milk, open, not dated 2. Soy Blenders (1) quart, open, not dated 3. Krusteaz Golden Waffle box opened, not sealed ,exposed to air 4. 30 to 40 loaves of frozen bread dated 11/24/2012, 3/25/2013, and 4/26/2013. 5. Sweet pickle relish, 1 gallon, open, undated 6. Signature Deluxe Mayo, 1 gallon, open, undated 7. Miracle Whip, open, undated 8. Picture of unknown substance, unlabeled 9. Rejuv 100% Orange juice, open, undated 10. Hunts Ketchup, 20oz. ,open, undated 11. Rejuv 100% Apple Juice, open, undated 12. Kosher dill pickle chips, open, undated Interview with Staff W revealed facility policy was to use frozen food within 3 months. Interview with Staff E revealed facility policy was to use frozen food items within 6 months. Cabinets and wire carts in Main Kitchen 1. Pancake syrup, 1 gallon, open, undated 2. Molasses, 1 gallon, open, undated 3. Vanilla flavoring, open, undated 4. White Vinegar, 1 gallon, open, undated 5. Soy Sauce, 1 gallon, open, undated 6. Worcestershire Sauce, open, undated	W 104	W 104 The Food Services Manager conducted an in-service training of all kitchen staff in the proper Diet Manual 5.7 procedures of labeling food in containers; either individually or bulk (to include inner individually sealed) containers. This in-service training will stress the need for such stringent control procedures; with an emphasis of the potential health and potential foodborne illness risk. These labels will identify the date an item is opened and its expiration. Items removed from their original container and transferred to another container will also be labeled identifying the contents of the item. All secondary containers will be in good repair or replaced. The Food Services staff will ensure that all labels are maintained in a serviceable and legible manner. During the handling of containerized food staff will be	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 104	Continued From page 2 7. Cereal in plastic pitchers (Chex, Rice Krispies, Corn Flakes), not labeled, undated 8. Premium Salad Oil, 1 gallon, open, undated Food Handler Cards Record review revealed 3 staff (Staff L, K & R) Food Handler cards were not posted on kitchen bulletin board and not available during survey. Record review also revealed 3 staff (Staff R, X & Y) were currently out on L&I with return dates unknown. Facility was unable provide information when main kitchen staffs ' Food Handler card expired when they were not posted on kitchen bulletin board. Interview with Staff W revealed all kitchen staff were expected to renew their Food Handler cards and post on bulletin board located in kitchen break area prior to expiration. Staff W revealed main kitchen staff will remove their Food Handler card from the bulletin board and take with them when renewing their card. Staff W acknowledged when Food Handler cards were not posted on the bulletin board there could be a multitude of reasons yet all kitchen staff were required to post their Food Handler card. ATP - Room #10 Observation on 09/11/13 of ATP program (Room #10) revealed 2 of 12 sample residents (Resident #8 and 12) and 4 of 116 expanded sample residents (Resident # 18, 69, 91 and 123) were served a mixture of coffee and cocoa mixed with expired milk dated of 09/8/2013. Sunrise Cottage Observation on 09/09/13 at 10:55 AM revealed that 2 hallway doors giving egress to the rear emergency exit at Sunrise House were locked and residents could not exit through the rear fire exit in the event of a fire or other emergency. Interview with Staff EE revealed they keep the hallway door locked to prevent male residents	W 104	mindful to view that each container is properly marked with the required information and the label is in a serviceable/legible condition. If a label becomes damaged it will be immediately replaced and marked with the aforementioned required information. The Food Services Manager or Cook 3 on a weekly basis will perform random inspections of food containers to ensure the serviceability and proper identification of food containers. The Food Services Manager with the technical support of the IT Office has developed and implemented a Food Handlers Card database on September 20, 2013. This data base has been created to track the date that food handling has been completed and date of expiration. Thirty days prior to a staff member's expiration date the database will notify the Food Services Manager and Cook 3 of an approaching expiration date and	

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W 104	Continued From page 3 from going to the female side of the cottage and to keep female residents from going to the male side of the cottage. Interview with Staff N revealed that residents could not evacuate Sunrise Cottage via the rear emergency exit in the event of an emergency because the hallway doors were locked. Pinewood Cottage Observation at Pinewood Cottage on 09/09/13 at 9:45 AM revealed the gate in a fence outside an emergency exit at Pinewood Cottage was tied shut, preventing residents from leaving the area in the event of an emergency. Interview with Staff T revealed the gate is used as an emergency exit away from the house and it was probably tied shut on 09/06/13. Pathway to Douglas and Hillside cottages Observation on 09/11/13 revealed approximately 10 decorative bricks stacked in front of a white bench along the pathway to Douglas and Hillside cottages posed a trip hazard and did not allow the ability for residents to use the bench if they needed to sit and rest. Interview with Staff J revealed that the brick had been stacked there when there had been some type of work done on the garden area and had not been put back. Staff J immediately moved the bricks behind the bench so that they no longer posed a trip hazard.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

will flag the impending staff members name in red. Additionally, the Food Services Manager and Cook 3 will review the database on the first work day of each month to identify any approaching renewals. All Food Services staff who handle food will immediately take the food handlers course and present their new card to the Food Services Manager or Cook 3 who will enter the new information into the Food Handlers Card database and will then post the new card on the Food Handlers Display board in the main Kitchen. Furthermore, the Food Services Manager has obtained all cards of staff members whom handle food and has entered their information into the Food Handlers Card database, and has placed them on the Food Handlers Display board in the main Kitchen. These measures will safeguard against any Kitchen staff member from handling food with an expired Food Handlers Card.

Adult Programs Supervisor will ensure all staff handling food items are labeled with date received and date expired tags. Proper utilization of Diet Manual 5.7 will ensure food items are fresh and the potential for foodborne illness eliminated. Adult Program staff will be in-serviced using Diet Manual 5.7 proper food labelling. In order to maintain compliance Adult Program Supervisor or designee will conduct random spot checks of refrigerators and cupboards where food is stored. Adult Program Supervisor checked refrigerator and cupboards during the annual audit during 9/9/13 – 9/13/13.

Cottage doors will be maintained to allow egress in case of emergency.

Although this was corrected during the week long survey September 9-13 the facility will provide training to cottage ACMs by November 13, 2013 of the importance of maintaining doorways in event of fire. All cottage doors used as exits will remain unlocked. Clients will be provided all necessary exits without the need of cottage keys. The facility will conduct random spot checks of cottages and other areas occupied by clients/residents. The facility will sustain this requirement through training opportunities and Q/A monitoring as well as peer review of cottages. The Safety Officer will also provide additional random spot checks to ensure this requirement is maintained. The facility has met with the Fire Marshall on September 30, 2013 and local jurisdiction on September 19, 2013, our procedure related to fire watch have been revised to include 15 minute checks of client/residents occupied areas and 30 minute checks in area not occupied by clients/residents. Procedures will be provided as attachments to the POC.

A fence in the yard of Pinewood cottage was found with a shoestring tying it shut. Although this is not an acceptable practice at the facility it was a finding during the survey. Staff will be reminded and trained that restrictions of this nature are not permitted on the campus. The facility will maintain this requirement by providing specialized staff development in-service trainings of staff on Pinewood. The Superintendent will send an all staff memorandum in electronic mail forbidding undocumented restrictions. All requests for restrictions will be documented in a positive behavior support plan and reviewed by the Human Rights Advisory Committee.

Completion Date: November 13, 2013 and ongoing.

Responsible: PAT Director/Facility Services Administrator.

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W 120	Continued From page 4 This STANDARD Is not met as evidenced by: Based on interview and record reviews, facility did not provide Physical Therapy (PT) services for 1 of 1 (Resident #3) sample residents between 06/16/13 and 07/03/13. This failure prevented Resident #3 from being evaluated for a proper mechanical lift sling, resulting in the resident being bed bound until seen by PT on 07/03/13. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of Resident #3 on 09/10/13 revealed that due to osteoporosis, bone/muscle degeneration and the [1, 3] fracture he is transferred by a mechanical lift using a full body sling. Record Review revealed Resident #3 's [1, 3] [1, 3] was fractured on 06/04/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. Resident #3 returned to the facility from the hospital on 06/11/13 after having a metal rod placed to secure the fracture. Review of resident #3 records revealed on 06/15/13 Resident #3 was seen by Staff II, a part-time Physical Therapist, who noted Resident #3 needed to be a 2 person or mechanical lift transfer, with no weight bearing. On 06/17/13 Staff LL wrote that staff to follow PT directions. On 06/19/13, Staff A noted that staff were not able to safely move Resident #3 manually and they need to get a proper lift with a full sling. On 06/19/13 Staff LL noted that PT " is not available to work with Resident #3 and staff can set him on	W 120	W 120 Services Provided by Outside Services The facility will ensure services with contracted providers are completed promptly by revising the Lakeland Village EVENT/INCIDENT REPORT notification box to include notification of a Physical Therapist. A Physical Therapist will be notified by the immediate investigator of a client fracture before the end of the shift. The initiation of this notification by the end of the shift will ensure that Physical Therapy services are implemented following a timely assessment/evaluation of the client. The facility has corrected the deficiency as it relates to Client #3 by updating the Physical Therapy assessment and updating the IPP to reflect Client #3's current physical status.	

Lakeland Village POC ATTACHMENT

Exit Date of Survey: 9-13-13

Tag 120 Continued from Page 5 of SOD

Modification of the Lakeland Village EVENT/INCIDENT REPORT occurred on October 23, 2013.

Immediate investigators will be in-serviced on LV 10:6.B CLIENT PROTECTION: IMMEDIATE INVESTIGATION to ensure that the Immediate Investigator of the Event/Incident Report is knowledgeable and responsible and has ensured that LV 10.6.B procedure is followed including notification of a Physical Therapist of a client fracture by the end of the shift.

Immediate investigators will be in-serviced by November 13, 2013.

The ICF DDA 1 or designee will review all incident reports to ensure timely notification of a Physical Therapist by the end of the shift.

The Quality Assurance Team Committee members will perform internal audits of all incident reports. CRU will be notified of all large bone fractures.

This will be completed by November 13, 2013 and ongoing.

Responsible: PAT Director/DDA 1 or designee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 120	Continued From page 5 the side of the bed to dangle but cannot get him out of bed." Staff JJ evaluated Resident #3 on 07/03/13 at 9:45 AM recommended a full body sling be used with the mechanical lift to transfer Resident #3. Interview with Staff KK on 09/13/13 revealed that no physical therapist was available to consult with staff regarding Resident #3 between 06/17/13 and 07/3/13 because Staff JJ had been on vacation.	W 120		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interviews, facility failed to ensure that 1 of 12 sampled residents (Resident #8) and 5 of 116 expanded sample residents (Resident #16, 45, 98, 99, and 112) had access to their tooth brushes and other toiletries. This failure prevented residents from independent grooming. Findings Include: All observations and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Observation of Big Foot cottage 94 side bathroom sink area revealed 2 locked clear plexi glass cabinets. One locked cabinet contained 6. toothbrushes and the other locked cabinet contained Dixie cups, mouthwash and a hairbrush. Interview with Staff F acknowledged cabinets	W 137		

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W137

The facility will ensure that clients have the right to retain and use appropriate personal possessions by having free access to their tooth brushes and other toiletries. In this specific instance personal possession – toothbrushes and toiletries were locked, but doesn't reflect facility practice as a whole. To ensure this can't happen again, locks have been removed on the two plexi-glass cabinets as verified on November 1, 2013.

Bigfoot cottage staff will be in-serviced on LV 3.1 - Protecting Client Rights and LV 3.14 Protecting Client Privacy. An all staff e-mail memo will be sent reminding staff members about client rights to their personal possessions.

ACMs will monitor their own cottages for violations of client rights to free access to personal possessions. Through the quarterly "Housekeeping, Safety, Sanitation and Physical Environment Self-Audit" form, a peer cottage will inspect the accessibility of personal grooming supplies.

The facility will conduct random Quality Assurance checks to ensure this practice is maintained. Any further occurrences will be rectified immediately. Staff will be provided clear expectation regarding client rights for personal belongings.

Completion: November 13, 2013 and ongoing.

Responsible: Superintendent/PAT Director or designee.

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	50G007	A. BUILDING _____ B. WING _____	09/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 137	Continued From page 6 should not have been locked.	W 137		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record reviews, facility failed to report an incident regarding 1 of 1 resident (Resident #3) resulting in a fractured femur for 1 of 1 (Resident #3) sample residents to the Complaint Resolution Unit (CRU). This failure prevented CRU from ensuring timely, prompt and appropriate follow-up of the incident. Findings include: Record review revealed on 09/10/13 Resident #3 's [redacted] was fractured on 06/04/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. Review of CRU Intakes for Lakeland Village revealed the facility did not report Resident #3 's [redacted] was fractured when a staff transferred him on 06/04/13. Interview with Staff BB on 09/11/13 verified that the facility did not report the 06/04/13 incident during which caused Resident #3 sustained the fracture to the [redacted]	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS. The facility must have evidence that all alleged	W 154		

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W 153 STAFF TREATMENT OF CLIENTS

The facility will ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source are reported immediately to the administrator or to other officials in accordance with state law through established procedures. The facility did notify Central Office and a Central Office Incident report was completed for Resident #3. As per facility practice all fractures are investigated by the CIMS. A CIMS investigation was completed for Resident #3. All large bone fractures will be reported to the CRU (hotline).

All staff will receive an e-mail MEMO referencing LV 10.6.C CLIENT PROTECTION: Reporting Suspected Abuse and Neglect to ensure that the CRU (hotline) notification is completed in accordance with state law. As per facility practice all fractures will continue to be investigated by the CIMS with a Plan of Correction/follow-up that is addressed by the Superintendent. All large bone fractures will be reported to the CRU.

The ICF has developed a Quality Assurance Team Committee to monitor incident reports, CRU and Central Office Incident reports.

The Quality Assurance Team Committee members will perform internal audits to review all incident reports and ensure compliance. The Quality Assurance Team Committee will continue to meet monthly.

Completion Date: November 13, 2013 and ongoing.

Responsible: Superintendent, PAT Director and DDA1.

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 7 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to thoroughly investigate an incident pertaining to 1 of 1 (Resident #3) sample residents sustaining a fractured [redacted] This failure placed Resident #3 at risk of harm from potential future incidents due to unclear directions regarding transfers. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Record review of Resident #3 ' s records revealed that the [redacted] was fractured on 06/04/13 when Staff HH transferred Resident #3 from a recliner to a wheelchair using a 1-person stand and pivot transfer technique. The 1-person stand and pivot technique required Staff HH to stand in front of Resident #3 seated in the chair, support and help lift Resident #3 when he stands. Then Staff HH and Resident #3 both pivoted toward the wheelchair and Staff HH helped lower the resident into the wheelchair. Review of the facility investigation dated 06/05/13 revealed the conclusion that Staff HH appropriately supported Resident #3 during the 06/04/13 transfer which resulted in Resident #3 ' s fractured [redacted] During a telephone interview on 09/13/13 Staff HH revealed that when he attempted to pivot Resident #3 toward the wheelchair, Resident #3 ' s body moved around but his right foot did not and Staff HH heard a loud " pop " sound. Staff	W 154	W 154 STAFF TREATMENT OF CLIENTS The facility will have evidence that all event/incidents are thoroughly investigated. The facility failed to follow outlined procedures regarding facility investigations. The LV Event/Incident report will contain all the documentary/ demonstrative and other relevant evidence. The immediate investigation is reviewed by the Administrative reviewer. The Administrative reviewer will ensure that all relevant evidence is preserved and provided to the CIM investigators. The CIM investigator will review the facility LV Event/Incident report to ensure the Central Office and CRU reports and relevant evidence is provided and the packet is complete. The HPA will update client #3 current IPP and the Physical Therapy assessment and provide clear direction regarding transfers. These documents have been updated to	

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W 154	Continued From page 8 HH stated he always did a one person stand and pivot when transferring Resident #3 from a chair to the wheelchair because that is what they were taught. The facility investigation did not reveal Staff HH failed to ensure Resident #3 ' s foot was free to turn during the transfer. Facility investigation also failed to identify these inconsistencies in the transfer requirements for Resident #3: 1. 11/12/09 Staff JJ recommended " ...a mechanical lift should be used if staff are not able to safely assist with stand-pivot transfers. " This documentation does not identify how staff are to know, prior to a problem occurring, if they are able to safely assist with transfers. 2. 10/03/12 Profile AP-PM (Room 5) for Resident #3 noted that Resident #3 needed a mechanical lift as adaptive equipment. 3. 04/19/13 Medical History and Physical for Resident #3 noted he was " able to stand, pivot transfer with the assist of 2 ... " 4. Physician Orders signed by Staff C dated 05/22/13 noted " Due to mobility limitations, use a mechanical lift PRN. " The documentation did not reveal when a mechanical lift should be used PRN. 5. Quarterly Nursing Health Care Review by Staff MM dated 05/17/13 noted, " Due to mobility limitations, use a mechanical lift PRN. " Documentation did not reveal when a mechanical lift should be used PRN. 6. Individual Habilitation Plan (IHP) dated 05/07/13 for Resident #3 noted, " Due to mobility limitations, use a mechanical lift PRN. " However, it also noted Resident #3, " Stands and assists in transfers ... " Documentation did not reveal when a mechanical lift should be used PRN or be used when Resident #3 can stand.	W 154	accurately reflect the client's current status. Completed for client #3 as verified on November 1, 2013. All staff will be in-serviced on LV 10.6.b, Client Protection: Immediate Investigations, LV 10.6 d Client Protection: Administrative Reviews. If the CIM investigator believes that additional information or other relevant documentation should be obtained they can access additional information electronically or in the Client Unit Record. The DDA 1 or designee will review the packet following the Administrative Review. The HPA's will conduct a Significant Change of Status meeting and provide documentation of significant events when a fracture changes the client's functional status. Update of assessments will occur so as to accurately reflect the client's current status and provide clear directions regarding client mobility.	

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The client's IPP will also be updated to reflect the client's current status.

The ICF has developed a Quality Assurance Team Committee and will continue to monitor LV Event/Incident reports and ensure through investigations by November 13, 2013 and on-going with reporting of findings to the DDA 1 and PAT Director for any needed corrections.

The Quality Assurance team/committee team DDA 1 or designee will review all administrative reviews to ensure compliance. The Quality Assurance Team Committee will continue to meet monthly.

Completion Date: November 13, 2013 and ongoing.

Responsible: Superintendent, PAT Director and DDA1.

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W 154	Continued From page 9 Interview with Staff B revealed he approved the 5-Day Investigation Report on 07/13/13.	W 154		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interviews and record review, facility failed to provide proper training for two staff members (Staff P & Q) who had recently begun working at Bigfoot Cottage regarding 1 of 116 expanded residents' (Resident #16) therapeutic diet. As a result Resident #16 was served the wrong diet. Findings include: Record review revealed on 09/09/13 Resident #16 at approximately 5:20 pm resident was given the wrong diet texture. Resident immediately began coughing. Nursing was notified immediately and assessed residents lung sounds for any signs or symptoms of aspiration. When the facility investigated the incident it was noted that neither Staff P nor Staff Q were aware of the diet that Resident #16 was to have, due to not being oriented to the residents on the cottage as is the policy of the facility.	W 189		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

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W 189

The facility will have evidence that staff are provided a cottage orientation. On 9/9/2013 the two staff in question (staff P and Q) were provided a cottage orientation immediately after the incident which included the client's diet. Staff involved believed they had received previous cottage orientation but evidence was not present.

ACM will in-service Bigfoot staff on LV 11.5 - Safety & Health Training/Education regarding cottage orientation to employees unfamiliar with the assigned area before starting duties; when the employee requests one; when an employee has not worked in the area in the past 30 days or when necessary due to changes. All other staff will receive an all staff memo reminding them about getting a cottage orientation per criteria above.

Completed orientations will be maintained on the cottage. All cottages will continue with their current method for retaining orientation forms on the cottage.

ACMs, during their monthly audit of meals, will ensure the staff working the cottage have been properly oriented.

Completion Date: November 13, 2013 and ongoing.

Responsible: PAT Director/ACM.

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W 249	Continued From page 10 treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, facility failed to provide a continuous active treatment program consistent with current IHP (Individual Habilitation Plan) for 1 of 12 (Resident #3) sample residents. This failure prevented the resident from having an opportunity to learn skill development and work toward accomplishing their objectives. Findings include: All observations, record reviews and interviews occurred between 09/9/13 and 09/13/13, unless otherwise specified. Resident #3 was observed on 09/11/13 from 2:20 PM to 2:45 PM. He was observed sitting in his wheelchair throughout this time. He did not participate in any activities during this time and occasionally appeared to be falling asleep. Interview with Staff NN revealed that during the afternoon class Resident #3 performs his program, pressing down on a jig, for about an hour before their break. A different resident performs this task after the break. When the other resident is using the jig, Resident #3 was not engaged in his program. Staff NN also explained that sometimes they do not have the parts to put into the jig and Resident #3 ' s	W 249	W 249 The facility will ensure that each client is provided a continuous Active Treatment program by offering activities/programs as stated in the IHP. The AP program that client #3 was on is being deleted. His AP program will not be centered on a task that involves production materials that may not always be available. His program will reflect more of what his assessed need is. The X on the Program Recording form indicates program not run with documented reason on back of the form. When the client has finished his formal objective and is willing to stay at the work site, AP staff will provide opportunities and let him choose alternate activities. If the client is tired, AP staff will exhaust all options to keep the client awake and engaged before sending the client home. AP Room 5 Program Managers will be in-serviced on accurate and	

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W 249	Continued From page 11 training program cannot be run. Staff NN stated that an X in the AP Monthly Reporting Program Recording Form shows the training program was not run that day and the reason it wasn ' t run should be explained on the back of the form. Review of Resident #3 ' s AP Monthly Program Recording Form reveals: 1. Resident #3 ' s training program was not done for 87 days from 04/08/13 through 09/12/13. 2. No reason is given on the back of the AP Monthly Program Recording Form explaining why the program was not run on 29 days between 04/08/13 and 09/12/13. 3. Comment on back of form by Staff NN notes Resident #3 ' s program was not run between 04/22/13 to 05/16/13 because there were no parts available to assemble. However, scoring on the front of the Recording Form shows the program was run from 05/13/13 through 05/16/13.	W 249		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, facility failed to obtain abridgement consents prior to implementation of restrictive programs that removed shower handles from shower rooms for 16 expanded sample residents (Residents ' # 19, 22, 37, 39, 40, 41, 42, 44, 53,	W 263		

appropriate program documentation by following the Graduated Guidance sheet. The Graduated Guidance sheet will be given to all other Program Managers explaining and emphasizing accurate and appropriate program documentation.

AP Supervisor/designee will monitor 5 programs for the accuracy of documentation on a quarterly basis and ensure corrections are made if needed.

HPA will monitor the delivery of active treatment through direct observation and make recommendations as needed and monitor program data monthly through the MPR process. HPA and their quarterly review will document evidence of said observations.

Completion Date: November 13, 2013 and ongoing.

Responsible: PAT Director/Adult Training Supervisor/HPA.

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W 263	Continued From page 12 58, 67, 77, 84, 87, 93, & 99). This failure denied the residents/guardians the opportunity to make informed decisions about facility restrictive practices and denied residents their right to shower independently at their residence. Findings include: All observations, record reviews and interviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of shower rooms at Apple 92/93 side, Bigfoot 92/93 side and Hillside 65 side revealed shower handles were removed from the shower areas. Record review of resident roster listed 22 residents who could shower independently without staff assistance. Interview with Staff U revealed shower keys were locked up to prevent the residents from turning on the water and staff were always present at shower times to ensure resident safety. Staff U provided surveyor with Lakeland Village directive dated 09/06/06 for bathing expectations for all Lakeland Village residents which stated bath keys (handles to the baths and showers) will be secured outside the bathing area. These may be stored in a secure manner or locked for resident safety. Interview with Staff B acknowledged this has been a facility practice following three incidents involving residents ' drowning. The only exception in having shower handles is on the 88 side of Wildrose. Facility was unable to produce abridgement consents for 16 residents who were independent and have the ability to shower without asking staff for shower keys or requiring	W 263	W 263 The Audit Team selected Level of Support 3 to indicate independent showering. LS3 in and of itself is not an accurate measure of showering skills/abilities. Of the 16 sited clients, the facility will ensure abridgements are completed on those who can shower independently. The facility will also continue to have staff follow the directive dated 9/6/2006 for bathing expectations that will be republished to all cottage staff with the same expectation which states bath keys (handles to the baths and showers) will be secured outside the bathing area. These may be stored in a secure manner or locked for client safety. Guardians will be provided the opportunity to review LV abridgement and restrictive procedure and provide input if any. The facility will look at all assessments to determine which	

clients have a level of independence in bathing/showering and ensure abridgments are completed on those who are independent in showering.

Annual direct care assessments will determine the level of assistance required by each client in the bathing/showering process, which will in turn determine if an abridgment will be needed. The bathing directive/expectation will be sent to all staff to review.

ACM and HPA will continue to monitor through staff observation and ensure the abridgement is valid and is reviewed and discussed when needed or at the Annual IHP.

Completion Date: November 13, 2013 and ongoing.

Responsible: Superintendent/PAT Director/DDA1/HPA.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 263	Continued From page 13 supervision while showering.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to provide 1 of 1 (Resident #52) expanded sample residents with pulse and blood pressure checks weekly as directed by nursing orders. This failure placed Resident #52 at risk of harm from potential medical complications. Findings include: Observation at 8:00 AM on 09/10/13 revealed Resident #52 was given [redacted] 3 20 mg as ordered. Resident #52 has received the [redacted] 3 since 06/12. Review of Resident #52 ' s records on 09/11/13 revealed a nursing order requiring Resident #52 ' s pulse and blood pressure should be taken once a week before hypertension medication is given and also as necessary. Review of the nursing orders from March 1, 2013, through September 11, 2013, reveal blood pressures and pulses were not taken: March 23 through April 4th, April 6th through April 18th, April 20th through May 23rd, June 1st through June 20th, June 29th through July 18th, July 20th through August 1st, August 3rd through August 16th, and August 24th through September 11th. Interview with Staff MM on 09/11/13 revealed that she was the team leader for Resident #52 and was not aware Blood pressure and Pulses were not being completed weekly.	W 322		

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W322-Physician Services

Client #52 will be provided preventative and general medical care as evidenced by providing a nursing review of the current chronic care plan for blood pressure and pulse checks. The blood pressure and pulse checks are taken weekly as directed by nursing orders to ensure Client #52's health and safety is protected. Increased vital sign monitoring of client #52 has been initiated to ensure stability of blood pressure and pulse on current medication. Client #52 will have an increase in monitoring of vital signs prior to medication administration from 10/17/13-10/31/13 to ensure stability on current anti-hypertensive medication. All nursing staff will be in-serviced regarding education of accurate vital sign assessment and when it is required as well as accurate documentation of the assessment prior to medication being given. Nursing procedure 2.4 outlining the documentation process in the health monitoring flow sheet will be attached to the in-service.

All Nursing staff will be in-serviced regarding education of accurate vital sign assessment and when it is required as well as accurate documentation of the assessment prior to medication being given. Nursing procedure 2.4 outlining the documentation process in the health monitoring flow sheet will be attached to the in-service. RN Team Leader will identify the clients receiving the type of medication the deficiency targeted (anti-hypertensives). The Medication Administration Pass Evaluation/Audit will ensure current nursing orders in the health monitoring flow sheet regarding vital sign assessments are being followed.

The RN3 or designee will perform Medication Administration Pass Evaluation/Audits on 5 clients per quarter to ensure current med administration procedures and nursing orders are being followed. RN Team Lead will receive in-servicing, focused training and teaching tailored to the specific type of error that was discovered.

ICF Quality Assurance Team Committee has been put into place to monitor Medication Administration Pass Audits to ensure continued effectiveness of systemic changes are permanent. The RN Team Leader will conduct quarterly audits clients to ensure vital sign assessments according to the nursing order are completed as part of the quarterly med review process and will be discussed with IDT at QMR regarding the client's stability on current anti-hypertensive medication.

The RN Team Leader and the RN3 who completes the medication audits will ensure the deficiency has been corrected on a quarterly basis.

Completion Date: November 13, 2013 and ongoing.

Responsible: RN4 and RN3 or designee.

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W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, facility failed to perform a recommended vision exam for 1 of 12 sampled residents (Resident #11). Failure to provide a vision exam placed resident at risk of unidentified changes in vision or other medical issues which could lead to deterioration in their overall health. Findings include: All interviews and record reviews were conducted between 09/09/13 and 09/13/13, unless otherwise specified. Record review revealed a 06/02/2009 Eye Examination report for Resident #11. The Eye Consultant recommended Resident #11 follow-up in three years. No further Eye Examination Reports were found in Resident #11 ' s records. Interview with Staff BB revealed Resident #11 ' s 06/02/2009 Eye Exam report was the most current on record.	W 323		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review, facility failed to ensure that 1 of 116 expanded sample residents (Resident #15) received the correct nursing interventions. This failure prevented Resident #15 from receiving the correct medication when admitted to the facility and having the potential for	W 331		

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Exit Date of Survey: _9-13-13_____

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W 323 PHYSICIAN SERVICES

The facility will have evidence that all clients are provided an evaluation of vision and hearing annually or as per recommendation of the Specialist/Consultant. Client #11 had an eye examination report dated 06/02/2009 with a follow-up recommended in three years. The HPA will ensure that client #11 has a current vision examination. Client #11 has an eye examination scheduled for October 17, 2013.

The Vision Database will continue to be updated by the Medical Services Coordinator to track vision examinations and follow-up. The Medical Services Coordinator schedules the eye examinations per due dates. Client refusals will be documented on the database by the Medical Services Coordinator. The HPA will document refusals on the IPP to accurately reflect the client's current status.

An e-mail memo by the DDA1 will be sent to the HPA's and Medical Services Coordinator to ensure that the Plan of Correction for Eye Examinations, client refusals and follow-up is implemented.

The ICF has developed a Quality Assurance team/committee which will monitor follow-up by reviewing 5 clients quarterly by November 13, 2013 and on-going with reporting of findings to the DDA 1 and PAT Director for any needed corrections.

The Quality Assurance Team Committee members will review 5 clients quarterly to ensure compliance. The Quality Assurance Team Committee will continue to meet monthly.

Completion Date: November 13, 2013 and ongoing.

Responsible: DDA1 or designee.

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W 331	Continued From page 15 harm. Findings include: Record reviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Resident #15 came with an order for [redacted] liquid 0.5mg twice a day. On 05/21/13, 05/22/13, and 05/23/13, Resident #15 received [redacted] liquid 5 mg twice a day instead of the prescribed 0.5 mg twice a day. Review of facility ' s 5-Day Investigation Report on 09/10/13 revealed that on [redacted] Resident #15 was admitted to the facility as a respite client. When Resident #15 was admitted Staff X received a copy of Resident #15 ' s discharge orders from the Group Home that Resident #15 had previously lived at. Staff X copied the Group Home ' s medication reconciliation record (MAR) which included the medication [redacted] liquid. Staff X informed the Health Care Provider (Staff C) that Resident #15 had one medication and that the dosage was 0.5mg. Staff X was asked to read the concentration from the label on the box of the medication that had arrived with the resident to Staff C. When Staff X gave the order to Staff C the order was transcribed incorrectly causing Resident #15 to get 5 mg of [redacted] twice a day instead of 0.5mg twice a day which was the actual order. This error continued for 3 days before a consultant found the error and brought it to the facility attention. Review of the facility ' s Nursing Procedure 9.5 pertaining to medication orders reveals: 1. Nursing staff are permitted to act on	W 331	W 331-Nursing Services The facility will provide clients with nursing services according to their needs. The facility failed to ensure that Client #15 received the correct nursing interventions. Resident will receive the correct nursing interventions including preventative and general medical care in the event he returns for respite care. The facility referred this medication error to the CIMS for a thorough investigation. Nursing staff that were involved in this medication error were in-serviced on Nursing Procedure 9.5 regarding appropriate and accurate doctor order transcription and verification. This in-service was completed on 7/2/13. All Nursing staff had been directed to review current nursing procedure 9.5 in order to prevent future medication errors and to ensure understanding of the procedure. Staff X was given individualized in-servicing on this	

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W 331	Continued From page 16 verbal/telephone orders provided the orders contain appropriate information and are within their scope of practice. 2. Verbal orders will be accepted ONLY in emergency/life threatening situations (i.e., medical STATS, hemorrhage, cardiac arrhythmia, shock, and coma.) 3. Telephone orders can ONLY be accepted and written by the RN/LPH and ONLY when the physician is off campus or involved in acute care (providing direct care to a client) or in a client emergency. 4. The nurse accepting the order must be the same nurse writing the order. 5. The RN/LPN will read back the order, in its entirety, to the physician at the time the order is given for verification prior to terminating the telephone call and write " Verified " after the notation " Telephone Order ". 6. All physician orders will undergo a " Double or Validation Check Process " within 24 hours of the original date and time the order was written. Example: if the order starts the process during shift one, it must complete the validation check no later than shift three. The facility did not follow their process which led to Resident #15 receiving the incorrect dosage of [redacted]3 for 3 days.	W 331		
W 332	483.460(c)(1) NURSING SERVICES Nursing services must include participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process. This STANDARD is not met as evidenced by:	W 332		

procedure as well. All in-servicing was done directly after incident occurred and was completed by 7/31/13.

The facility has ensured that additional transcription and verification errors would not occur by immediately in-servicing all Nurses on current Nursing Procedure 9.5. Following the medication error Nurses were immediately notified after the incident to ensure that the nursing staff were aware of the procedure regarding taking and processing of verbal or telephone orders only when appropriate as stated in the procedure through in-servicing as well as monitoring doctor orders through the pharmacy to ensure no verbal or telephone orders are being written during hours that the ARNPs are on campus, unless in an emergency.

ICF Quality Assurance Team Committee has been put into place to monitor continued effectiveness of systemic changes are permanent.

RN4 ensured in-servicing was done to correct deficiency and ensure no further errors occurred. July 2, 2013 and July 31, 2013.

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W 332	Continued From page 17 Based on record review and interviews, facility failed to review and update the End of Life/Palliative Care Plan Consent for 1 of 1 sample residents (Resident #11). This failure placed resident at risk of not receiving medical treatment in accordance with any health care changes. Findings include: All record reviews and interviews were conducted between 09/09/13 to 09/13/13 unless otherwise indicated. Record review of End of Life/Palliative Care Plan (Revised date 04/13/2011) for Resident #11 revealed resident has a terminal diagnosis of recurrent [redacted] secondary to [redacted] Record Review of End of Life/Palliative Care Plan Informed Consent was signed by Staff OO, Staff X and Staff PP on 03/15/2012. Staff QQ and Staff RR signatures were noted on file for 09/09/2010 and Staff SS signature was noted on file for 09/10/2010. Record review of End of Life/Palliative Care Informed Consent for Resident #11 revealed the forms will be reviewed and updated when the plan changes or at the annual IHP meeting. Interview with Staff BB revealed that the current End of Life/Palliative Care Plan for Resident #11 was in the file and the informed consent had not been updated since 03/15/2012.	W 332		
W 334	483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination.	W 334		

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W 332 NURSING SERVICES

The facility will have evidence that Nursing Services have participation as appropriate in the development, review and update of the IPP as part of the Interdisciplinary process. The IDT will update and review the End of Life/Palliative Care Plan for Resident #11. IDT members and the guardian will sign a STATEMENT OF UNDERSTANDING AND PARTICIPATION form to document that the Palliative Care Plan has been discussed when the plan changes or at the annual IHP meeting.

The HPA and the IDT members will meet when the Palliative Care Plan is changed/updated or annually at the IHP meeting. IDT members and the guardian will sign a STATEMENT OF UNDERSTANDING AND PARTICIPATION form to document that the End of Life/Palliative Care Plan has been reviewed. This documentation will ensure that the clients are not at risk of not receiving any medical treatment with any health care changes.

LV Policy 8.03 End of Life/Palliative Care will also be reviewed by the HPA's who are responsible for revisions.

The Quality Assurance Team Committee member HPA will review all Palliative Care plans to ensure compliance and the QA Committee will continue to meet monthly to monitor and ensure compliance.

Completed Date: November 13, 2013 and ongoing.

Responsible: PAT Director/DDA1/HPA.

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W 334	Continued From page 18 This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to complete quarterly nursing physical assessments for 12 of 12 sample residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, & 12). This failure placed residents at risk for decline of health and well-being due to unidentified health issues from lack of/or incomplete review and/or examination of body systems. Findings include: All interviews and record reviews were conducted between 09/09/13 and 09/13/13 unless otherwise stated. Record reviews revealed: • Resident #2 had no documented Quarterly Nursing Health Care Reviews (direct examination of the resident) within the past year; however the named Resident had quarterly nursing chart reviews in place. • Resident #3 had Quarterly Nursing Health Care Reviews dated 2/21/13, 5/21/13, and 8/1/13. None of these quarterly reviews revealed a direct examination of the resident had been completed. • Resident #4 had a Quarterly Nursing Care Review dated 07/31/2013, Annual Nursing Review and Recommendations dated 07/10/2013. None of these reviews revealed a direct examination of the resident had been completed quarterly. • Resident #5 did have the IMR Quarterly Nursing Health Care Reviews for the chart reviews completed. Resident #5 had an IMR Quarterly Physical Assessment (one of the facility forms for the direct examination of the resident)	W 334	W 334 NURSING SERVICES The facility will have evidence that Nursing Services have completed quarterly nursing physical assessments. A direct physical examination will include a visual review of the body as well as examination/observation of body systems. The physical exam will be completed as evidenced by the completion of the updated "NURSING HEAD-TO-TOE PHYSICAL ASSESSMENT" for the following clients; 1,2,3,4,5,6,7,8,9,10,11,& 12. The Clients listed in the deficiency will have nursing head-to-toe physical assessments completed. The nursing staff will identify clients who have not had a quarterly physical assessment in the last 6 months. The identified clients will receive a "NURSING HEAD-TO-TOE PHYSICAL ASSESSMENT" by November 13, 2013. This documentation will ensure that the clients are not at risk of decline of health and well-being due to	

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W 334	Continued From page 19 that was dated 08/14/13. Three direct examinations of the resident were not completed. Resident #6 had no documented Quarterly Nursing Care Reviews. On 9/12/13 staff were able to locate one Quarterly Nursing Direct Physical Examination, dated 1/16/13. Resident #7 had Resident had Quarterly Nursing Chart Reviews completed for the year. None of these quarterly reviews revealed a direct examination of the resident had been completed. Resident #8 had Quarterly Nursing Care Reviews dated 06/12/2013 and 09/4/2013. An Annual Nursing Review and Recommendations dated 07/06/2013. One direct examination of the resident was completed on 06/18/2013. Resident #10 had an ICF-ID Quarterly Physical Assessment completed on 07/19/13. No direct examination of the resident had been completed quarterly. None of these quarterly reviews revealed a direct examination of the resident had been completed. Resident #11 had completed Quarterly Nursing Health Care Reviews for July 2013, April 2013, January 2013 and an Annual Nursing Review dated 02/28/2013. . None of these quarterly reviews revealed a direct examination of the resident had been completed. Resident #12 had one Quarterly Nursing Direct Physical Examinations, dated 7/30/13. Three direct examinations of the resident were not completed. Interview of Staff A revealed that the facility ' s policy titled " Quarterly Nursing Health Care Review, " documented a Registered Nurse or designee will use the quarterly physical assessment and MOSES (a tool used for monitoring of side effects) form and be	W 334	unidentified health issues from lack of or in-complete review and/or examination of body systems. All nurses will receive an in-service on Nursing Procedure 1.6 ICF-ID Quarterly Nursing Health Care Review which will be revised to ensure the definition of head-to-toe assessment includes that all documentation will ensure that the clients are not at risk of decline of health and well-being due to unidentified health issues from lack of/or in-complete review and/or examination of body systems. The RN3 or designee will perform audits on 5 clients per quarter to ensure current procedures regarding quarterly physicals are followed. Completion Date: November 13, 2013 and ongoing. Responsible: PAT Director/RN4/DDA1.	

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W 334	Continued From page 20 responsible for completing three of the four required direct physical)assessments per year.	W 334		
W 367	483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. This STANDARD is not met as evidenced by: Based on observation, record review and interviews , facility failed to provide for accurate drug administration and identification up to the point of administration for 1 of 12 sample residents (Resident #8) and 1 of 116 expanded sample residents (Resident #16). This failure placed residents at risk for potential harm from receiving the wrong medication. Findings include: Observation of medication administration on 9/10/2013 at 8:00am revealed Staff DD preparing medication for administration for Resident #16. Staff DD was observed punching the medication from the bubble packs for Resident #16 into a Dixie cup. Staff DD then prepared medication for another resident (Resident #8). Staff DD left the medication room to give Resident #8 his medication leaving medication for Resident #16 sitting on the counter in the medication room. Record review of the facility ' s General Principles of Medication Administration Policy (Revised 04/25/2010) revealed the RN/LPN (Registered Nurse/Licensed Practical Nurse) are assigned the responsibility for preparation, administration and documentation of the medications and the security of the drug storage area. The RN/LPN will prepare and set up medications for one	W 367		

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W 367	Continued From page 21 resident at a time followed by immediate administration of the medication. Interview with Staff DD regarding AM medication administration for Resident #16 on 09/10/2013 revealed Staff DD had gotten distracted and left Resident #16 ' s medication on counter. Staff DD acknowledged that she should have given to Resident #16 the medication before leaving the area and not have leaving them in a medication cup on the counter.	W 367		
W 425	483.470(d)(2) CLIENT BATHROOMS The facility must provide for individual privacy in toilets, bathtubs, and showers. This STANDARD is not met as evidenced by: Based on observation, record review and interview, facility failed to ensure 2 of 12 sample residents (Resident #5 & 10) and 12 of 116 expanded sample residents (Resident #20, 26, 28, 29, 47, 82, 83, 88, 90, 97, 101, 106) had privacy while bathing. This failure to provide privacy violated the 14 residents ' right to privacy. Findings include: Observation 09/13/13 of Hillside Cottage (64 side) hydro tub area revealed a section of the privacy curtain missing and would not provide a resident privacy while bathing. From the hallway entrance the hydro tub was visible. Record review revealed that the last work order to replace the privacy curtain was on 01/22/13. Interview with Staff CC acknowledged a missing.	W 425		

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W367-Drug Administration

Clients #8 and #16 will be protected from listed deficiency by re-educating staff DD on the appropriate procedure of medication administration. An in-service with the Nursing Procedure 4.1 on October 17, 2013 on medication administration was provided along with a memo that was placed in all med rooms regarding the need to have only authorized staff in the medication room.

The facility will have an organized system for drug administration that identifies each drug up to the point of administration. All nursing staff will be in-serviced regarding education of accurate medication administration NP 4.1 as well as a memo sent out outlining authorized staff that may be in the med room when the nurse is not in the room. The procedure on preparing medication for one client and administering the medication immediately will be emphasized. As there are instances when a client may become unable or unwilling to take the medication, the procedure clearly states that the medication cup will be labeled with the clients name and the MAR will be flagged. If this occurs and the nurse is needed elsewhere, the prepared medication must be locked in the medication room or in the med cart in the designated area. The nurse must check by the end of the medication period to ensure all medication was given. This will be put into memo form as well for clearer understanding.

The RN3 or designee will perform Medication Administration Pass Evaluation/Audits on 5 clients per quarter to ensure current med administration procedures are being followed. Staff DD will have individual in-servicing on correct set-up and administration of medication as well as the memo being placed in all med rooms.

ICF Quality Assurance Team Committee has been put into place to monitor Medication Administration Pass Audits to ensure continued effectiveness of systemic changes is permanent.

Completion Date: November 13, 2013 and ongoing.

Responsible: RN4, RN3 or designee.

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W 425	Continued From page 22 portion of the privacy curtain for the hydro tub area. He stated there is a resident that likes to tear down the curtains and a work order had been submitted. Staff CC revealed someone most likely just forgot to record in record book. Staff CC indicated a plan to resubmit a work order to replace the missing privacy curtain.	W 425		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to ensure infection control practices were observed in 2 of 2 kitchens (Main and Pinewood Cottage). Food preparations in the main kitchen and Pinewood Cottage were completed in a manner which could cause cross-contamination. These failures placed residents at risk of illness due to improper usage of gloves. Findings include: All observations and interviews occurred between 9/9/13 and 9/13/13, unless otherwise specified. Observation of food preparation in main kitchen area on 9/9/2013 revealed: 1. A staff wearing gloves while kneading meat. Staff later removed her gloves, washed her hands, picked up a new pair of gloves and placed the gloves on a soiled counter before putting new gloves on. 2. A staff wearing gloves chopping lettuce in a container and pushing the lettuce down with her hands. Staff then opened the kitchen drawer to obtain an item and continued chopping lettuce	W 455		

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W 425

Privacy was provided to the Hillside clients using temporary curtains until the permanent curtain could be installed using the proper hooks.

The installation of the permanent curtain was accomplished on October 10, 2013. This is not a pervasive issue on the campus, however if a privacy curtain is removed by client behavior the curtain will be replaced prior to bathing activities. Client privacy will be maintained.

ACMs will monitor their own cottages for privacy issues. Through the "Housekeeping, Safety, Sanitation and Physical Environment Self-Audit" form, a peer cottage will inspect areas for privacy and report any deficiencies immediately to the appropriate ACM for correction.

The ICF has developed a Quality Assurance team/committee with audit tools in which peer review audits will occur on a neighboring cottage at least quarterly.

The Quality Assurance team/committee will review the quarterly peer audits to ensure deficiencies are completed in a timely fashion.

Completion Date: November 13, 2013 and Ongoing.

Responsible: PAT Director/ACM.

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W 455	Continued From page 23 and pushing down the lettuce with the same pair of gloves. 3. A staff labeling Styrofoam food containers proceeded to use scooping utensils which had been laying on dirty dish towels to scoop fruit cocktail into Styrofoam containers. 4. A staff kneaded meat while wearing gloves then picked up a 1 gallon jug of sauce and poured the sauce into the meat. Staff hand kneaded the meat using the same gloves. Interview with Staff E revealed staff are expected to wear gloves during food preparation and are expected to change gloves if other items are touched. Observation of food service during lunch at Pinewood Cottage on 9/11/13 revealed: 1. Staff FF spread margarine on 6 slices of white bread while wearing gloves. He touched the bread, the container of margarine, the knife he used to spread the margarine, the plate he put the bread on, as well as touching the counter and the refrigerator door, all while wearing the same gloves. Staff FF had handled several beverage containers using his bare hands. Then Staff FF removed a straw from a wrapper without gloving or sanitizing his hands and placed the straw in Resident #3 ' s beverage, while holding the end of the straw that Resident #3 put in his mouth. 2. Staff GG touched bowls, removed lids, touched the table, and removed the wrapper from slices of cheese. He then broke up the cheese and put it on Resident #14 ' s food, all while wearing the same pair of gloves.	W 455		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and	W 460		

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W 455

Food Services Manager and ACMs will conduct an in-service training of all kitchen and direct care staff in the proper use of gloves, utensils, hand washing and handling food to prevent cross contamination as outlined in the Diet Manual 5.3. The Food Services Manager or Cook 3 on a weekly basis for the next 6 months will periodically perform quality assurance checks of staff members to ensure proper compliance with the newly established procedures; after that time period they will perform these quality assurance checks on a bi-weekly cycle. ACMs will conduct a Meal Observation audit on all 3 meals within the month and point out any discrepancies in this process to the worker.

The PAT Director will ensure Cottage Meal Observation audits are conducted and the Quality Assurance Team Committee will do 3 random meal audits and report the results to the appropriate ACM.

Completion Date: November 13, 2013 and ongoing.

Responsible: PAT Director/Facility Services Administrator.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 460	Continued From page 24 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, and record reviews, facility failed to ensure 1 of 116 expanded sample residents (Resident #29) received the proper liquid thickening agent consistency and 2 of 116 expanded sample residents (Resident #16 & 17) received the correct diets. This failure prevented Resident #29 from receiving the correct amount of thickening agent for her fluids which could have led to aspiration of the fluids and Resident #16 & 17 from receiving the correct diets which placed them at risk of harm for aspiration. Findings include: All observations and record reviews occurred between 09/09/13 and 09/13/13, unless otherwise specified. Observation of lunch on 09/10/13 at approximately 11:05 am revealed that at Hillside Cottage, Staff noted the consistency of Resident #29 ' s meat gravy was too thin (pudding thick). The staff member took the container (Styrofoam 1 quart) to the cottage kitchen and got the thickening agent out of the cupboard and began pouring a couple of spoonful ' s of the thickening agent into the container and began mixing it. The staff person then served the thickened gravy to the resident. The staff person did not follow the directions on the side of the container; therefore there was no assurance that the gravy he prepared for Resident #29 had the proper consistency for resident. Record review of facility incident report for	W 460	W460-Food and Nutrition Wrong Liquid Thickening Agent Consistency. The facility will ensure that each client is receiving a nourishing, well balance diet including modified and specialty-prescribed diets. The facility will ensure that Client #29 receives the proper liquid thickening agent consistency. The Speech Pathologist will in-service the Hillside care staff directly regarding adding THICKENER to food products and mixing to the desired consistency (spoon/pudding thick). Upon training completion, Client #29's care staff will sign a "Staff Development Attendance Record Specialized Training" form. Wrong Therapeutic Diet. Resident #16 received the wrong therapeutic diet which came prepared from the kitchen. Resident #16 ate the wrong therapeutic diet before the staff could intervene. This incident was	

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W 460	Continued From page 25 08/14/13 revealed Resident #16 received the wrong therapeutic meal. Resident #16 is a respite resident (admitted 08/13/13) at the facility and was admitted on a Gluten Free diet (A gluten-free diet is a diet <http://en.wikipedia.org/wiki/Diet_(nutrition)> that excludes foods containing gluten <http://en.wikipedia.org/wiki/Gluten>. Gluten is a protein complex found in wheat. <http://en.wikipedia.org/wiki/Wheat> , barley <http://en.wikipedia.org/wiki/Barley>, and rye <http://en.wikipedia.org/wiki/Rye>. A gluten-free diet is the only medically accepted treatment for celiac disease <http://en.wikipedia.org/wiki/Coeliac_disease>). Resident #16 ' s dinner was prepared by the kitchen staff and came in a dinner tray. When it was time to eat, staff became distracted by another resident having behaviors, and Resident #16 ate the food before staff could intervene. When staff became aware of the error they contacted nursing staff and had resident evaluated right away. Resident did not have any residual problems from eating the wrong diet. The facility investigation notes that the Staff L did not follow the proper procedure to ensure that the resident received the proper diet. Record review of facility incident report for 09/09/13 revealed Resident #17 received the wrong textured diet when Staff P handed Staff Q a bowl of soup to give to the resident. Resident #17 is to receive a dysphagia mechanically altered diet with slurry bread products and honey or spoon/pudding consistency liquids. Resident #17 received soup that consisted of kidney beans, potatoes and noodles that were overcooked. Resident began to cough and staff immediately removed the soup from in front of	W 460	thoroughly investigated by the CIMS. All Kitchen staff were in-serviced regarding "gluten free diets". This in-service was completed on 9/4/13. Wrong Textured Diet. The facility will ensure that each client is receiving a nourishing, well balance diet including modified and specialty-prescribed diets The facility will ensure that Client #17 receives the proper textured diet and liquid consistency. The Speech Pathologist will in-service Client#17's care staff (Bigfoot). directly regarding the visual identification of his specific food texture. Upon training completion, Client #17's care staff will sign a "Staff Development Attendance . Record Specialized Training" form. Also, the "Cottage Orientation Sheet" includes the diet textures and liquid consistencies for all the clients. When new or floating staff are assigned to the cottage, a regular staff member will review	

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W 460	Continued From page 26 resident and notified the nurse. Per the facility investigation the facility had not ensured that the staff working on the cottage (Staff P and Q) was properly trained to the unit.	W 460		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews, facility failed to serve food at the appropriate food temperature for hot and cold items at Bigfoot and Pinewood cottages, Failure to serve food at the appropriate temperatures resulted in residents being served food at inappropriate temperatures creating potential for foodborne illness. Findings include: All observations and interviews occurred 09/11/13, unless otherwise specified. Bigfoot Observation at 11:30 AM revealed a special diabetic meal containing a ground unknown substance and gravy was served at 120° (temperature to be 140 degrees or higher when served) to 1 of 116 expanded sample residents (Resident #121). Pinewood Observation of cold food temperatures at 11:25 AM revealed the cold foods arrived from the main facility kitchen above the maximum safe temperature of 45 degrees. Mixed fruit was 51.6 degrees and pureed fruit was at 48.5 degrees. Interview with Staff B revealed the cottage is the last stop for meal delivery and that the cold foods are not kept in insulated containers during	W 473		

the Cottage Orientation Sheet's information with said staff. Cottage staff have been trained regarding cottage orientation for new staff and any staff that hasn't worked on Bigfoot in the last 30 days per procedure. In-service training was completed on 9/16/13.

Wrong Liquid Thickening Agent Consistency.

All staff that has contact with clients will have training on proper liquid thickening agent consistency. An on-line training video "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS" will be available to Lakeland Village. All staff that has contact with clients will complete this on-line training. The training will include accurate identification of liquid/food consistencies (from NECTAR to SPOON/PUDDING thicks) and the proper methods of using THICKENERS to attain the desired consistency.

Wrong Therapeutic Diet.

The" Substitution Book" was updated in the kitchen with a page titled "gluten free" which includes a list of items with gluten in them, for staff to use as a reference. All kitchen staff were in-serviced on "gluten free" in the substitution book. This in-service was completed on 8/27/13.

Wrong Textured Diet.

All staff that has contact with clients will have training in visually identifying "modified textured diets" and "thickened liquid consistencies." An on-line training video available to Lakeland Village "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS". All staff that has contact with clients will complete this on-line training. The training will include "accurate identification of modified diet textures. (i.e., Dysphagia Mechanically Altered) and thickened liquid consistencies (i.e., Spoon/Pudding thicks).

Current staff will complete the "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS" on-line training by November 13, 2013 and, thereafter, will complete the said training as part of their Annual Employee Update Training requirements. All NEW employees will receive this specialized training during their initial New Employee Orientation Training and annually thereafter.

Wrong Therapeutic Diet.

Kitchen staff members whom prepare meals for individuals whose dietary requirements consist of gluten free based meals will be cognizant to review all food provisions and ingredients to ensure that all proper gluten free substitutions are prepared as per dietary necessities.

The Food Services Manager conducted an in-service training of all kitchen staff in the proper procedures to identify food items which contain stuffings that are gluten based. Also staff members were reoriented with the proper procedures of identifying gluten based food and where to locate that information in the

substitution book. This book contains a Gluten Free page which lists food items that contain gluten; staff members will review the substitution book to identify information specifically related to substitutions for gluten free diets. Kitchen staff members whom prepare meals for individuals whose dietary requirements consist of gluten free based meals will be cognizant to review all food provisions and ingredients to ensure that all proper gluten free substitutions are prepared as per dietary necessities. The Food Services Manager or Cook 3 will randomly perform food preparation quality checks on staff members whom prepare gluten free meals.

Upon completion of the "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS "on-line training, the employees pin # will be recorded on the Staff Development Data page. All supervisors and IT personnel will have access to the Staff Development Data page to ensure all staff have completed this training. The Food Services Manager or Cook 3 will randomly perform food preparation quality checks on staff members whom prepare gluten free meals.

Dates when corrective action will be completed.

November 13, 2013.

Wrong Liquid Thickening Agent Consistency.

Lakeland Village Speech Pathologist will complete Hillside on-site training of client #29's care staff by October 31, 2013.

Wrong Textured Diet.

Lakeland Village Speech Pathologist will complete Bigfoot on-site training of client #17's care staff by November 13, 2013.

Speech Pathologist will ensure training is completed with Hillside care staff for client #29's "Thickener" issue by October 31, 2013. Supervisors will ensure that their staff has completed the initial on-line training, "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS," as well as the annual update training requirements.

Speech Pathologist will ensure training is completed with Bigfoot care staff for client #17's "Wrong textured diet" issue by November 13, 2013. Supervisors will ensure that their staff has completed the initial on-line training, "FOOD TEXTURES and LIQUID CONSISTENCY MODIFICATIONS," as well as the annual update training requirements.

Completion Date: November 13, 2013 and ongoing unless otherwise stated.

Responsible: PAT Director/Speech Pathologist.

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W 473	Continued From page 27 delivery.	W 473		
W 478	483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based observations, interviews, and record reviews, facility failed to ensure meal choices were offered to 1 of 12 sample residents (Resident #10) and 3 of 116 expanded sample residents (Resident #29, 88, & 90) that received specialized diets. This failure does not provide the resident with meal choices when on a specialized diet. Findings include: Observation on 09/10/13 at Hillside Cottage at approximately 11:20 am revealed Resident #10 was given a metal tin that contained her specialized diet (ground meat/rice milk). Resident #10 ate the meat without being asked if she would rather have something else to eat that would fit into her diet plan. Observation lunch time on 09/10/13 revealed Staff did not offer meal choices to Resident #29, 88 or 90 on Hillside Cottage. Resident #29 was given a puree diet that was served up by the staff from the metal tin that had been prepared in the main kitchen and at no time was she offered an alternative to what she had been served. Resident #88 was served a mechanical soft diet that had come from the main kitchen. Resident #88 was assisted in scooping the food onto her plate and no time was she offered an alternative	W 478		

Lakeland Village POC ATTACHMENT

Exit Date of Survey: _9-13-13_____

Tag __473___ Continued from Page __28___ of SOD

W 473

The Food Services Manager has reorganized the food delivery route and distribution process. Food articles will only be loaded in the delivery vehicle immediately prior to departure to the cottages. Food deliveries will be divided and delivered on two separate treks. Each of these deliveries will be all those cottages located on either the north campus or the south campus as positioned from the main kitchen. The reduction in delivery time of the reduced travel route will assure that client/residents food is delivered to the proper cottage at the appropriate food temperature. The Food Services Manager or Cook 3 has given instructions of the new process to all staff.

Completion Date: November 13, 2013 and ongoing.

Responsible: Facility Services Administrator/Food Manager/Cook3.

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W 478	Continued From page 28 meal choice. Resident #90 had a regular diet that came in a metal tin already prepared from the kitchen that he was able to scoop out onto a plate with some cueing from the staff. Resident #90 was independent in getting his meal tray from the kitchen counter, opening it and placing the food on his plate. Staff did not asked if he would like something different to eat instead of what he received from the main kitchen. Record review on 09/10/13 revealed that Resident #10 was on a specialized diet (ground meats with no added salt and no dairy) for all meals secondary to choking issues. Review of facility diet sheet that was provided facility management on 09/09/13 verified the diets for Resident #10 and 29 ' s specialized diets.. Interview with Staff J on 09/10/13 after the lunch meal revealed that all the residents on the specialized diets are to be offered an alternative. Staff J stated she did not know why staff had not offered an alternative to the residents as it is an expectation.	W478	W 478 The facility will ensure clients have choices at meal times even those on a special diet, by providing appropriate alternative choices. Staff will ask clients if they want what is in their special diet tray or an alternative that still meets the requirements of their special diet. An all staff memo will be sent out with reminders to staff to provide choices at meal times. ACMs will do meal time audits of all 3 meals on a monthly basis to ensure choices are being offered. Completion Date: November 13, 2013 and ongoing. Responsible: PAT Director/DDA1/ACM.	

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

November 2, 2012
CERTIFIED MAIL (7008 1300 0000 7157 1947)

Diane Kilgore, Superintendent
Lakeland Village
PO Box 200, Mailstop: B32-25
Medical Lake, WA 99022

RE: Recertification Survey
10/13/2012 through 10/17/2012

Dear Ms. Kilgore:

From 10/13/2012 through 10/17/2012, ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/IID File

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	50G007	A. BUILDING _____ B. WING _____	10/17/2012

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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Lakeland Village on October 13, 2012 to October 17, 2012. A sample of 13 resident was selected from a census of 125. The Expanded Sample included 29 residents. The survey was conducted by: Janette Buchanan RN BSN Terry Patton RN BSN Penelope Rarick BA David Piotrowski QMRP (Federal Surveyor) The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-2419 Fax: (360) 725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to insure the facility staff handled and stored food properly. Failure to handle and store food properly puts clients at risk of food borne	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Diane M Kilgore — Acting Superintendent — 11/16/2012

...deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ...llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...rogram participation.

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W 104	Continued From page 1 illness. On 10/13/12 at 4:30 AM, an inspection of the kitchen area on Apple 92 revealed that the refrigerator had 3 unopened Health Shakes, expiration date 3/12 and 1 pan covered with plastic wrap labeled Clear Diet Food, undated. The freezer held a large brown paper bag of hash browns, no original container, loosely closed with tape, no date; 20 frozen Health Drinks, expiration date of 3/12; an opened, unsealed package with pancakes, dated 8/31/12; an opened, unsealed bag containing chicken nuggets, no seal, significant freezer burn; a large, unsealed brown paper bag containing French toast, no original container, undated. The pantry cupboards held one opened protein powder with an expiration date of 5/2010 and one non-opened protein powder with an expiration date of 05/2012. On 10/13/12 at 10:00 AM an inspection of the kitchen area on Apple 93 revealed that the refrigerator had an opened barbeque sauce with an expiration date of 11/14/2004; 3 small plastic containers of snacks with covers, 3 small plastic containers with salads with covers- all were labeled with clients ' names but had no date on the container (they appeared to be from a previous meal prepared by the facility kitchen). The freezer had a large, unsealed brown paper bag containing French fries, no original container, undated, and they had significant freezer burn. The pantry cupboard held 12 boxes of unopened, thickened dairy drink with the expiration dates of 08-27-12. On 10/13/12 at 10:45 AM observations of the freezers in the Willow residence revealed that waffles, hash browns, and pancakes were in an open bag that were not sealed or dated, there were 6 containers of meatloaf that had a date of	W 104	Plan of Correction for W104 **In order to protect the cited clients and all clients of Lakeland Village, the following measures will be implemented:** 1. The ICF/ID clientele reside on 9 cottages all with like and similar refrigerator/freezer units and cupboard space for dry food storage. All cottage staff are supervised by an Attendant Counselor Manager (ACM); each ACM will provide training to all cottage staff that handle and store food including the requirement to know the location of the cottage diet manual and be familiar with the content. Cottage staff will be required to read Diet Manual 5.6 & 5.7 procedures and will sign that they have been inserviced and understand the content of each document. Cottage staff will be trained in the expectation that items received from the kitchen will be appropriately labeled in order for the content to be recognizable by staff and clients. Each item will be labeled with the date it is received and the date it expires. All kitchen items will be stored in clean sealed packages that protect the food from contamination. Bulk food will be used and resealed per Diet Manual. Any and all foods that are stored on cottage will be discarded according to expiration dates. If during visual inspections food items which appear to have freezer damage or are found without a proper seal will be discarded in order to prevent any foodborne illness. Any food items left over from meals will be labeled with date received and discarded once they reach expiration. Food left over will be offered to the owner periodically following the meal. Clients may choose to consume or refuse the leftover food item. Refrigerator/freezer units as well as food cupboards will be visually inspected by designated staff daily. Any food items placed into storage will be rotated so that the oldest stock is used first. Cottage staff will be retrained by the ACM by 11/27/12.	

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W 104	Continued From page 2 3/26/12 on them. Observations of the refrigerators in the Willow residence revealed an orange substance in 2 containers that was not dated or labeled; a container of mustard that was expired 9/26/12; package of cheese slices that was open and not dated; and 2 brown bags of celery that were open and not dated, one with significant wilting notable. On 10/14/12 at 11:45 AM Client #1 was observed in the Cascade residence. Client #1 stated to his Attendant Counselor (AC) (Staff E), he wanted to make lunch. Client #1 then went to the freezer and pulled out a clear plastic bag of frozen chicken nuggets and tater tots that were in a brown paper bag. Neither of the packages was easily discernible to verify the contents and neither was dated indicating when the bags were originally opened. On 10/14/12 at 1:30 PM two kitchens were inspected in the Wildrose residence. Wildrose side 88 refrigerators had one prepared salad in non original container, sealed with plastic wrap, undated; an opened mustard container, expired 08/25/12; an unidentifiable salad type meal in a bowl with no cover, no label, and no date. The freezer contained an unidentifiable frozen food which appears to have fallen out of a container, significant freezer burn, sitting on freezer shelf. Wildrose side 89 refrigerators contained a container of mayonnaise, which expired 5/12; a large can of soup, opened, stored in the can with foil placed on top, no label, no date; 2 large tubs of cottage cheese in original containers, opened, expired 10/06/12. The pantry cupboards had 2 large original containers of peanut butter, one opened with an expiration date of 03/12, and one not opened with an expiration date of 03/12. In observations on 10/15/12 at 7:30 AM, at	W 104	2. All Food Services staff will be trained by the Food Services Manager. Training will include the need to recognize broken and/or damaged bulk food storage units and to discard these items. Food stored in bulk containers will have the content labeled and labeling will be easily recognizable. Bulk containers are periodically cleansed/sanitized. When cleaning/sanitizing labels become faded or are removed by high heat and scrubbing, kitchen staff will remove bulk container and lids and visually inspect for damage and appropriate labeling. If damage to containers occurs they will be removed, discarded and replaced. Replacement containers will be available at all times should damage occur. Food Services staff will be retrained by the Food Services Manager by 11/27/12. 3. Food Services staff will label all bulk food containers; labels will remain legible at all times. The Food Services Manager will inspect weekly to ensure containers remain labeled and are in proper condition in order to protect the food content preventing potential foodborne illness. The Food Services Manager has ordered and received additional food storage containers. The Food Services Manager will maintain the inventory and have sample additional containers readily available at all times. November 16, 2012 and ongoing. 4. ACM or designee will check the content of refrigerator/freezer and cupboards inspecting content for received dates and expiration dates daily. ACM or designee will also rotate stock noting any damaged or unsealed improperly stored food items. ACM or designee will discard food items that have outlasted their dates of expiration. ACM will retrain staff if the deficiency continues and take appropriate just cause action as needed. November 16, 2012 and ongoing. 5. Food Services Manager will make weekly checks of container used to store bulk food items to monitor storage containers and ensure they are undamaged and safe for food storage. November 16, 2012 and ongoing.	

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W 104	Continued From page 3 Cascade in a refrigerator, a food item labeled enchiladas was in the freezer and was dated 11/17/11. On 10/16/12 at 8:00 AM inspection of the main kitchen revealed that there was a broken top to the Farina container in both the front and back section on one side and had a smaller lid that did not provide adequate covering to those areas leaving the container open with the potential for something to fall into the container. When the Dietary Manager was interviewed she stated she was aware of the broken lid and stated a new lid had been ordered. On the containers that had cornstarch, brown sugar, and potato flakes there were no labels on the containers that said what was in the containers leaving a chance that one of these items could be mistakenly used incorrectly. Dietary manager stated that her staff knew what was in the containers therefore no mistakes could be made.	W 104	6. Quality Assurance Team members will complete monthly reviews of cottage units to ensure food stored in refrigerators/freezers and cupboards meet safe storage standards as outlined in the diet manual. The facility has 9 ICF/ID cottages the Q/A team will monitor 33% of the cottages monthly with 100% of the cottages reviewed every 90 days. Any negative findings will be reported to the ACM, Superintendent, and PAT Director. November 2012 and ongoing. 7. Quality Assurance team will inspect the kitchen monthly checking deficiencies identified in the annual audit. Q/A will also monitor for other deficiencies and report to the Kitchen Supervisor in order to prevent potential foodborne illness. November 2012 and ongoing. 8. An informational memo will be provided to all staff advising them of these expectations and training by the Superintendent. The Superintendent, PAT Director and Food Service Manager will ensure employees follow this plan of correction. November 16, 2012 and ongoing.	
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that each	W 196	Plan of Correction for W196 **How the Facility Will Correct the Deficiency as it Relates to the Client.** The facility will ensure a continuous active treatment program by Inservicing the ACM or designee and the Adult Program Supervisor or designee who are program managers as described in Work Procedure LV 7.12 for Clients listed; 1,6,8,10,14. The program managers will be responsible for observation, monitoring, implementation, modification and program development on a monthly basis. The program manager or designee will review program data on an ongoing basis for accuracy and ensure necessary modifications, updating and recording occurred to promote progress. The program manager will report to the HPA with concerns as needed. The HPA will monitor the programs for these individuals and their programs quarterly and will update and revise the programs in the IHP as needed. The IDT assessments will be reviewed by IDT and the HPA who will coordinate the overall IHP implementation to assess and	

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W 196	Continued From page 4 sampled client received a continuous active treatment program that was thoroughly and systematically reviewed and enhanced based on each client ' s individual capability and performance. The facility ' s failure compromised each client ' s ability for skill development and increased independence. Findings include: For Client #1: On 10/15/12 facility record review revealed an active treatment objective developed for Client #1 on 1/25/12. The objective was a three piece assembly task requiring Client #1 to hammer two grommets into a pipe. Task success criterion was 80% upon verbal prompt. Task success data recorded was 50% for May 2012; 24% for June 2012; 33% for July; 30% for August 2012; and 27% for September 2012. An associated note for September performance documented Client #1 " Participated in 22 sessions this month ...; has been steadily more resistive to participating in class, often refusing to even sit at the table. Consider change to program focus. " The facility made no change to the objective or measure in response to the regression noted. No specific target date for completion was developed. Record review of Client #1 ' s Behavior Support Plan (BSP) on 10/16/12 revealed Client #1 had restrictions in place including: 1:1 visual supervision; restrictions to personal property; monitoring of phone, TV, mail, radio, computer/Internet use and search as procedures designed to prevent targeted problem behaviors. The plan also included administration of psychotropic medication for agitation, distress and insomnia. Documented behavioral objectives for Client #1 for six consecutive months were: zero episodes of aggression, property .	W 196	determine if the program (s) continue to be appropriate for the clients listed: 1,6,8,10,14. HPAs and program managers will complete these actions by December 17, 2012 and ongoing. Monitored by QA Committee and DDA 1. **Administration of Psychotropic Medication and Documented Behavioral Objectives.** Client #1 will have a plan in place to modify psychotropic medications required for designated target behaviors. The facility HPAs will ensure that all clients with medication reduction plans are reviewed. Medication reduction plans will be included on the IHP and incorporated into behavior modification programs. Medication reduction plans will be reviewed during the Quarterly Medication reviews. The assigned HPA and Quarterly Medication review will be completed by December 17, 2012 and ongoing. Monitoring by the QA Committee and DDA 1. **Labeled Bin Usage During Meals.** Client #6: The utilization of labeled bins used for place setting at meal times is a practice that has been eliminated for this individual. Client #6 will be assessed for adaptive equipment which will enhance their independence if needed. All clients will have their adaptive equipment needs assessed at the IHP and as needed to ensure that clients are as independent as possible. HPA will ensure adaptive equipment needs have been addressed by December 17, 2012 and ongoing. Monitoring by the QA Committee and DDA 1. **The Facility will Act to Protect Residents in Similar Situations.** ACMs or designees will be inserviced on program management to ensure that Work Procedure LV 7.12 is followed and the program managers or designees if assigned by the IDT are knowledgeable and responsible for the individual program development, implementation, observation and monitoring on a monthly basis. The program manager or designee will review program data on an ongoing basis for accuracy and ensure necessary monitoring, updating and recording occurred to promote progress. The program manager will report to the HPA with concerns as needed. The HPA as the primary QDDP will coordinate overall IHP implementation, monitor programs on a quarterly basis and will update or revise the programs for	

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W 196	Continued From page 5 destruction, self-injurious behavior, inappropriate sexual expression, unauthorized absences and agitation. The facility failed to have a plan in place to modify 1 of 3 medications based on data collected regarding designated target behaviors. For Client #6: Per record review on 10/13/12 Client #6 is self sufficient in the use of all meal utensils. Observation on 10/16/12 at 11:30 AM revealed Client #6 and all of the clients in his residence had their individual meal utensils (glasses, cups, plates, bowls, forks and spoons) kept in a small plastic bin labeled for each client. Prior to eating lunch each individual client or a staff would take a labeled bin from the cabinet then the clients would use the items in the bin during their meal. On 10/16/12 at 1:20 PM, Client #6 was observed working in the cardboard recycling active treatment work area. Client #6 performed several tasks without any assistance or directions from staff. Client #6 was not given an opportunity to use the orange pallet jack to remove the pressed bale of cardboard from the press which was part of his IHP and was given a 0 for the day. Zero scores are calculated into client ' s monthly report for participation working toward his goals. Per interview with Staff F the results will be skewed giving an inaccurate accounting of client ' s progress toward completion of the goal. For Client #8: On 10/15/12 at 8:55 AM, Client #8 was observed at the breakfast meal. Client #8 ' s AC (Staff I) attempted to feed Client #8 with an adaptive spoon. Occasionally, Staff I tried to get her to hold the spoon, but Client #8 refused and pushed the spoon away. Individual Habilitation Plan (IHP) dated 11/2/11	W 196	the IHP for each individual client as needed. The IDT assessments and programs will be reviewed at their annual IHP. HPAs and program managers will be inserviced by December 17, 2012. **Measures the Facility will take or the Systems it will Alter to Ensure the Problem does not recur.** The ICF will develop a quality assurance team/committee with audit tools to monitor program management, program implementation, medication modification plans and adaptive equipment by December 17, 2012 and ongoing with reporting of findings to the DDA1 and PAT Director for any needed corrections. **How the Facility plans to Monitor its Performance to make sure the Solutions are Sustained.** The Quality Assurance Committee team members will perform internal audits of at least 5 clients monthly to review and ensure compliance and will meet monthly for the first six months and quarterly thereafter. December 17, 2012 and ongoing with reporting of findings to the DDA1 and PAT Director for any needed corrections.	

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W 196	Continued From page 6 indicates Client #8 will touch her spoon with 80% success. Review of the quarterly reports for 2012 show that the client has had a decline in her participation with handling the adaptive spoon. Monthly reviews associated with this objective showed that the client was to continue with the objective as written. The HPA failed to revise the plan when regression was noted in the vocational training program. For Client #10: Client #10 was observed at breakfast, lunch and dinner over the course of meals offered on 10/13/12 and 10/14/12 in Client #10 ' s residence. The client used a built-up handle spoon. At all meals, Client #10 was noted to be able to eat independently with the use of the built-up handle spoon. Client #10 ' s records do not document the need or reason for his use of a built-up handled spoon at meals. On 10/15/12 at 1:00 PM Client #10 was observed at the horticulture program. Client #10 was seated in a wheelchair engaged in watering plants that had been placed in front of him on a tray. When Client #10 finished the task he propelled himself towards the corner of the room. Client #10 had the following vocational training objective: will remove empty 4 inch container from tray. Client #10 had been steadily more resistive to participating in class, often refusing to even sit at the table according to facility records. A monthly review dated 9/11/12 notes " consider a change to the program focus. " The facility records fail to address a response to Client #10 ' s regression in this training objective. For Client #14: Record Review on 10/16/12 revealed Client #14 is to be given opportunities and encouraged to spoon his own medications in applesauce and	W 196		

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W 196	Continued From page 7 self-administer the medication orally. Observation of Client # 14 on 10/13/12 at 7:50 AM revealed Staff M spoon fed Client #14 ' s medications in applesauce directly into his mouth. On 10/13/12 Staff M stated Client #14 will not take medications himself and she therefore must spoon them into his mouth. The facility does not record and document Client #14 ' s progress regarding the medication self-administration program.	W 196		
W 230	483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be assigned projected completion dates. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to establish skill training objective completion dates for five of six clients. Failure to identify completion dates diminishes the clients ' opportunities to improve skills and provides little framework for staff to evaluate clients ' active treatment progress. Findings include: On 10/15/12 Staff I was observed attempting to feed Client #8 a meal with an adaptive spoon. Occasionally, the Staff I tried to have Client #8 hold the spoon, but the client refused and pushed the spoon away. Record review for Client #8 on 10/15/12 revealed four skill objectives: Touch her spoon at 80% with prompts; before entering the bathroom, touch the bathroom door handle at 80% with prompts; Grasp a warm washcloth at 80% with prompts; Activate a foot switch to operate a footbath 80% of the time with prompts. No target dates were identified for any of the four	W 230	Plan of Correction for W230 **In order to Protect the Cited Clients and all Clients of Lakeland Village the Following Measures will be Implemented.** The facility HPAs will ensure that objectives of the individual program plans will be assigned projected completion dates for clients #1,6,8,12,13. Completion dates will be assigned to each objective on which the individual is currently working on. Completion dates will be individualized. For each objective assigned priority, the team will assign a projected date (month and year) by which it is believed that the individual will have learned the new skill, based on all of the assessment data. This date will trigger the team to evaluate continuously whether or not the individual's progress or learning curve is sufficient to warrant a revision to the training program. The assigned HPAs for the cited clients will complete these actions by December 17, 2012 and ongoing. Monitoring by QA Committee and DDA 1. The facility HPAs will ensure that objectives of all client individual program plans will be assigned projected completion dates for each objective on which the individual is currently working on. Completion dates will be individualized. For each objective assigned priority, the team will assign a projected date (month and year) by which it is believed that the individual will have learned the new skill, based on all of the assessment data. This date will trigger the team to evaluate continuously whether or not the individual's progress or learning curve is sufficient to warrant a revision to the training program. The assigned HPAs will add this information during upcoming program reviews and new IHP development. December 17, 2012 and ongoing. Monitoring by QA Committee and DDA1.	

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W 230	Continued From page 8 objectives. Record review on 10/16/12 revealed Client #1 ' s skill objectives included: Read a tape measure at one inch increments 80% of the time at a verbal prompt level; mop bedroom floor 100% of the time on a self - reliant basis; follow the ear mold cleaning instructions 100% of the time with verbal prompts. None of the objectives had target completion dates. Record Review on 10/16/12 revealed Client #6 had four skill objectives: After meals or snack times place the milk or juice container back in the refrigerator 80% of the time without any prompts; when given clean clothing put pajamas/socks/underwear in the appropriate drawers of his dresser 80% of the time when prompted by a gesture; after a bale of cardboard has been produced push the orange pallet cart 10 feet away to the pallet 80% of the time with upper arm or less assistance; when planting seeds push soil around 50% of the base of the seedling 80% of the time with forearm or less assistance. No target dates were identified for any skill objectives. Per record review on 10/16/12, Client #12 had a skill objectives as follows: Choose between two liquids 100% of the time based on verbal prompts; after brushing teeth return toothbrush to grooming drawer 80% of the time with verbal prompts and after using the restroom flush the toilet 100% of the time with verbal prompts. None of these three skills objectives had projected target completion dates. During observations of meals in the Willow residence on 10/13/12 and 10/14/12, Client #13 dished up one item of food onto her plate. Per record review for Client #13 on 10/16/12 it was revealed that Client #13 had a skill objective	W 230	The ICF will develop a Quality Assurance team/committee with audit tools to monitor programs assigned completion dates on the individual program plans by December 17, 2012 with reporting to the DDA1 and PAT Director. The Quality Assurance Committee team members will perform internal audits of at least 5 clients monthly to review and ensure compliance. The committee will meet monthly for the first six months and quarterly thereafter. December 17, 2012 and ongoing with reporting of findings to the DDA1 and PAT Director for any needed corrections.	

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W 230	Continued From page 9 incorporated on 05/24/12 to take up to one serving of each food item when dishing up food " 60% of the time. There was no projected target completion date identified.	W 230		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interviews the facility maintained restrictive practices without the review or consent of clients, guardians and/or parents. This failure denied clients access to personal items. Findings include: On 10/13/2012 an inspection of Apple residence revealed locked cabinets that contained toothbrushes, razors and various other self care items. There were no signed consents from the clients, guardians and/or parents agreeing to the restriction. On 10/13/12 and 10/14/12 an inspection of Apple residence and Wildrose residence revealed locked drawers containing kitchen knives and scissors. There were no signed consents from the clients, guardians and/or parents agreeing to the restriction. On 10/14/2012 an inspection of Wildrose residence revealed locked cabinets that contained chewing tobacco for Client #5. The client was allowed a 1/8th teaspoon of tobacco 7 times per day and the tobacco can only be accessed by staff. There were no signed	W 263	Plan of Correction for W263 **In Order to Protect the Cited Clients and all Clients of Lakeland Village the Following Measures will be Implemented.** The facility will ensure that restrictive practices are conducted only with the written, informed consent of the client, parent (if the client is a minor) or legal guardian. Items that are currently locked up on Apple and Wildrose residences will be reviewed and determined if the access to knives and scissors are a safety hazard. Written consent will be obtained and present prior to implementation of any restrictive program such as locking cabinets. Abridgement of client rights will be reviewed by the HRAC (Human Rights Advisory Committee) at Lakeland Village as per DDD Policy 5.10, and additional Positive Behavior Support policies. The consent will be informed and the person giving the consent will be informed of the risks, benefits, alternatives, right to refuse and consequences. Client #5 will have a written, signed consent in place for tobacco use, with an identified need and justification for the level of support and monitoring. Lakeland Village staff will ensure the safety of possessions while at the same time, clients will have access to their personal items, i.e. toothbrushes, razors and various other self-care items. The assigned HPAs will complete the appropriate abridgements by December 17, 2012. Monitoring by QA and DDA1.	

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W 263	Continued From page 10 consents from the clients, guardians and/or parents agreeing to the restriction.	W 263	The Facility will act to Protect Residents in Similar Situations. The facility will ensure that restrictive practices are conducted only with the written, informed consent of the client, parents (if the client is a minor) or legal guardian. Items that are currently locked up on every cottage/residence will be reviewed and determined if that access is a safety hazard. Written consent will be obtained and present prior to implementation of any restrictive program. Abridgement of client rights who are denied access will be reviewed by the HRAC at Lakeland Village as per DDD Policy 5.10 and additional Positive Behavior Support policies. Work procedure LV 3.2 will be followed which includes: Individuals rights that are abridged will include the identified need and justification for a specific level of support, exercising the right would be physically injurious, a specific right would infringe on the rights of others, a person does not comprehend the consequences of an action related to a specific event. The consent will be informed and the person giving the consent will be informed of the risks, benefits, alternatives, right to refuse, and consequences. Lakeland Village staff will ensure the safety of possessions while at the same time, clients will have access to their personal items, i.e. toothbrushes, razors and various other self-care items. The assigned HPAs will complete the appropriate abridgements by December 17, 2012 and ongoing. Monitoring by QA Committee and DDA 1. **Measures the Facility will take or the Systems it will Alter to Ensure the Problem does not recur.** The ICF will develop a quality assurance team/committee with audit tools to monitor abridgements and client's access to personal items by December 17, 2012 with reporting to the DDA1 and PAT Director. **How the Facility Plans to Monitor its Performance to make sure the Solutions are Sustained.** The Quality Assurance Committee team members will perform internal audits of at least 5 clients monthly to ensure compliance and will meet monthly for the first six months and quarterly thereafter. December 2012 and ongoing with reporting of findings to the DDA1 and the PAT Director any needed corrections.	

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

November 28, 2011
CERTIFIED MAIL 7007 1490 0003 4205 8293

Diane Kilgore, Superintendent
Lakeland Village
PO Box 200
South 2320 Salnave Road
Medical Lake WA 99022

RE: Annual Recertification Survey 10/31/2011 through 11/4/2011

Dear Ms. Kilgore:

From October 31, 2011 through November 4, 2011, ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey conducted at Lakeland Village School on 10/31/11, 11/01/11, 11/02/11, 11/03/11 and 11/04/11. A sample of 13 residents was selected from a census of 126. The survey was conducted by Gerald Heilinger Janette Buchanan Terry Patton Mark White The survey team is from: Department of Social and Health Services Aging and Disability Services Administration ICF/ID Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809	W 000	RECEIVED DSHS/ADSA JAN 06 2012 Residential Care Services Certified Residential Programs	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the failed to ensure the facility fixed a damaged bench, table, and door and also failed to properly store corn meal. Failure to properly store food may lead to contamination of the food. Failure to properly maintain a fire exit door and facility furniture may result in injury to Residents. The facility does not	W 104	Plan of Correction for W104 1. The Superintendent will issue a directive to all Lakeland Village employees and volunteers to follow the requirements of Lakeland Village procedures LV 9.4 "Hazards: Identification and Response"; LV 9.5 "Monitoring IMR/NF Living Units/Training Areas"; LV 9.8 "Safety Inspection Program"; LV 10.12 "Safety: Responsibilities of Managers, Supervisors, Employees" and LV 10.21 "Work Orders" to immediately report any maintenance, environmental health and safety problems. Area supervisors including AC Managers and members of the Safety Committee conduct regular safety auditing using the forms attached to these procedures. Safety Committee members will audit their assigned areas quarterly. Area supervisors including AC Managers will conduct monthly safety inspections. All staff and volunteers	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Duane McKenzie — Admin Supt. — Jan 4, 2012

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD; PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 have a system which assures staff follow an ongoing and sustainable program which requires staff to immediately report maintance, environmental health and safety problems and assures the problems are promptly corrected before residents are harmed.. The findings include: 1. On 11/2/11 observation revealed the mitered trim around a wooden bench in front of Pinewood House was splintered, coming apart, and a screw was protruding. Residents who use the bench could injury themselves. Direct care staff (staff #2) verified that Residents use the bench. 2. On 11/2/11 direct care staff (staff #2) was observed hitting her hip against a fire exit door at Pinewood House to force the door open. Residents who were weak or disabled could be put at risk during a fire. Staff #2 verified the door had required force to open it for 2 or 3 days, since the weather had turned cold. 3. On 11/2/11 two twenty-five pound paper bags of corn meal were observed sitting behind an empty cart on the floor of the freight elevator of the facility's kitchen where. Dietary Staff (staff #4) verified the corn meal was on the floor of the freight elevator because there was not room on the cart for the paper bags of corn meal earlier in the day when staff moved food items from the outdoors loading dock to the basement dry storage area. 4. Observation on 11/1/11 of a picnic table at a facility recreation area called " Frog Hollow " revealed a board was broken with a part of it	W 104	finding a safety and/or environmental hazard are expected to take steps to immediately protect any clients from the hazard or safety issue and submit a work order to correct the problem. As part of the annual performance plan review process all staff are to review the Lakeland Village Procedure Manual annually and document on the Annual Review Checklist that they have done so. Completion Date: 12/30/11 and ongoing 2. A work order was submitted by the AC Manager to repair the bench; the work was completed by CSS on November 2, 2011. Completion Date: 11/2/11 3. A work order was submitted by the AC 3 on Pinewood that was difficult to open. The repair was completed by CSS on November 2, 2011. Completion Date: 11/2/11 4. Dietary staff will be retrained in the requirement not to place food items on the floor by the Food Manager. This will include a reminder not to overload the food cart when using the elevator to the extent the cart becomes unbalanced requiring food items to be placed on the floor when entering and/or exiting the elevator. Food Manager and/or designee will conduct periodic spot checks (at least monthly for six months and quarterly thereafter) to verify food is not being stored and/or placed on the floor. Completion Date: 1/6/12 and ongoing 5. A work order was submitted by the Recreation Specialist to repair the picnic benches and tables at Frog Hollow on November 10, 2011; the repairs were completed by CSS on November 13, 2011. Completion Date: 11/13/11	

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

October 27, 2010

BY FACSIMILE

Diane Kilgore, Acting Superintendent
Lakeland Village
Po Box 200
Medical Lake, WA 99022-0200

RE: Recertification Survey 10/04/2010-10/14/2010

Dear Ms. Kilgore:

Included with this letter you will find the draft CMS 2567 Statement of Deficiencies (SOD) which resulted from a recertification survey completed on 10/14/2010.

Please be advised of your right to review this draft survey and submit any additional information to clarify or dispute the survey team's findings. Your response should be faxed to the ICF/MR Quality Assurance office and arrive no later than two working days after the date the draft was faxed to your facility.

In the event that there is not a dispute with the survey findings, or once any disagreements pertaining to the survey report have been resolved, the SOD will be considered final and the Plan of Correction (POC) will be due within ten calendar days of receipt of the final SOD.

In order to meet the ten day timeline, you may write the POC onto the faxed copy of the SOD for review by the ICF/MR survey team and fax it back to this office, signed and dated, to:

ICF/MR Survey and Certification Program
Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7176 Fax (253) 593-2809

After review of the POC by ICF/MR team, the original SOD will then be mailed to your facility in order to add the acceptable POC. A copy of the guidelines for an acceptable POC is included with this fax.

Thank you for your attention to this matter.

Sincerely,

Tom Farrow, Field Manager
ICF/MR Survey and Certification Program

REQUIREMENTS FOR AN ACCEPTABLE PLAN OF CORRECTION

Authority:

42 CFR 488.28(a), 488.456 (b)(1)(ii), 488.28(a)(c)(1)(2)(i,ii)(d), 442.105(b), 442.110(c)(2), 442.101(d)(3)(ii)

CMS State Operations Manual (SOM), Publication 7, Transmittal #1 3/98 (2728)(3007), Transmittal #6 3/99 (3006.5)

Acceptable Plan:

1. All data tags cited on a survey must have a plan of correction.

2. The first page of the plan of correction must be signed, dated, and include the title of the individual signing the plan. Subsequent pages of the plan must be signed or initialed and dated by the person signing the plan.

3. The plan of correction must be received by the ICF/MR office no later than ten calendar days after the provider's receipt of the statement of deficiencies.

4. Core elements of the plan of correction: (each element needs to be specific and realistic)

   a. How the corrective action will be accomplished for Individuals found to have been affected by the deficient practice;

   b. How the facility will identify other Individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect Individuals in similar situations;

   c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

   d. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and

   e. When corrective action must be accomplished (within a reasonable period of time - generally no longer than 60 calendar days).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2120 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is a result of a Recertification Survey conducted at Lakeland Village from 10/4/10 through 10/14/10 completed by Gerald Hellinger, Kathy Heinz, Mark White, Terry Patton and George Rogers from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, review of written procedures and interviews, it was determined the facility failed to insure nursing staff correctly implemented medication administration procedures. Two of seven nurses were observed not following the facility medication procedures. Findings include: 1. Observation on 10/5/10 at 10:25 AM at Bigfoot [redacted] revealed that a nurse left the medication cart in the dining room and went to the	W 104	Plan of Correction for W104 1. Facility will retrain the 2 involved nursing staff on Nursing Procedure 4.1 Medication Administration and Nursing Procedure 6.2 Enteral feeding tubes to insure they are aware and comply with the contents of the procedure. Facility will then spot check the nurses involved and insure correct compliance with the procedure. Responsible Person: RN4/Nurse Educator Completion Date: 11/30/10 2. All nursing staff will review Nursing Procedure 4.1 Medication Administration and Nursing Procedure 6.2 Enteral feeding tubes to insure they are aware and comply with the contents of the procedure. Responsible Person: RN4s Completion Date: 11/30/10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane M. Gile — TITLE: Adm & Supt — (X6) DATE: 11/5/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Oct. 27. 2010 2:54PM No. 0143 P. 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	50G007	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 TV/Living room carrying an unlabeled cup and gave the medications in the cup to Sample Resident #7. The nurse did not have a picture of Resident #7 with him and he had initialed the Medication Administration Record (MAR) prior to administering the medication. Review of the facility's Nursing Procedures 4.1 and 2.6 on 10/7/10 revealed that nurses administering medication to a resident away from the medication cart must write the resident's name on the medication cup, compare the resident's picture to the resident, and not initial the MAR until after the medication is administered. Interviews on 10/6/10 and 10/13/10 with the Registered Nurse 4 verified that Nursing Procedures 4.1 and 2.6 are in effect and should have been followed. 2. Observation on 10/7/10 at 8:00 AM at Apple [redacted] of a nurse during medication administration passes to 2 Expanded Sample Residents (#18 and #19) revealed that the nurse did not wear gloves, did not use hand sanitizer, and did not wash her hands. In addition, the nurse spilled medications onto the top of the medication cart, then picked up the medications with her bare fingers and administered the medications to the resident. Review on 10/7/10 of the facility's Nursing Procedure 4.1 reveals the nurse is required to change gloves, wash hands, or use hand sanitizer when contaminated and between residents. This procedure also requires that any medications must be disposed of after contacting the surface of the medication cart, which had been contaminated by the nurse and her clothing touching it. Interview on 10/13/10 with the Registered Nurse 4 verified that Nursing Procedure 4.1 is in effect and should have been followed. 3. Observation on 10/7/10 at 9:00 AM at Apple	W 104		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	50S007	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 209 MEDICAL LAKE, WA 99022

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W 104	Continued From page 2 [redacted] of a nurse revealed that the nurse left the medication room with unlabeled cups and went into the TV/Living room and administered the medications in those cups to Sample Resident #14 without comparing a picture of the Resident to him. The nurse administered the medications through Resident #14 ' s gastric tube (external tube used to give nutrition and medications to the resident). However, the nurse did not flush the gastric tube with water after the last medication, before starting the Resident ' s liquid feeding. Review on 10/13/10 of the facility ' s Nursing Procedure 6.2 reveals the nurse must always flush the gastric tube with water after administering medications. Nurse Procedure 4.1 requires that nurses administering medications away from the medication cart must write the resident ' s name on the medication cup and compare the resident ' s picture to the resident. Interviews on 10/7/10 and 10/13/10 with the Registered Nurse 4 verified that Nursing Procedures 4.1 and 6.2 are in effect and should have been followed.	W 104		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct fire drills for each house, during each shift, for each quarter of the year. Findings include: Review on 10/6/10 of the facility ' s fire drill reports revealed that 84/85 Sunrise did not document that fire drills had been conducted in October and November of 2009 or July 2010.	W 440	Plan of Correction for W440 1. The front desk will send out via email notification monthly to all areas informing them of their fire drill requirement. Responsible Person: Front Desk Monitor: Safety Officer Completion Date: 11/3/2010 Plan of Correction for W441 1. The area supervisor/designee will insure compliance to varied conditions/times that fire drills are conducted. Responsible Person: Area Supervisors Monitor: Area Directors Completion Date: Ongoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 440	Continued From page 3 Interview with the facility Plant Manager on 10/7/10 verified that those drills had not been documented.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct fire drills at different times of the day. Findings include: Review of the facility's fire drill reports on 10/6/10 revealed that all of the facility's houses conducted all of the night shift fire drills between the hours of 5:30 AM and 6:30 AM. In addition, 95 Bigfoot, Evergreen and 72/73 Pinewood conducted the afternoon shift fire drills between 3:00 PM and 4:30 PM for all four quarters. Three of four afternoon fire drills for 78/79 Willow were conducted between 3:30 PM and 3:33 PM. Interview with Administrative staff on 10/7/10 verified the drills were conducted during those time frames.	W 441		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to investigate a documented problem that occurred during a fire drill at 59 Douglas. Findings include:	W 448	Plan of Correction for W448 1. The area supervisor/designee will insure any problems that arise during a fire drill will be investigated and documented on a Plan of Correction attached to the Fire Alarm Report. Responsible Person: Area Supervisors Monitor: Area Directors Completion Date: Ongoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	50G097	A. BUILDING _____ B. WING _____	10/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	8211 EAL NAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 448	Continued From page 4 Review on 10/6/10 of the facility ' s fire drill reports for 59 Douglas revealed two Residents refused to evacuate the building during the morning shift fire drill held at 10:23 AM on 4/28/10. Interview with administrative staff on 10/7/10 verified that two Residents refused to evacuate the building and there was no investigation to determine why they refused to evacuate the building or if this was a chronic problem. In addition, the administrative staff revealed there was no facility system in place to insure investigations were conducted following identified problems that arose during fire drills.	W 448	2. The area supervisor/designee will insure their staff are knowledgeable of procedure changes through their staff meetings. Responsible Person: Area Supervisors Monitor: Area Directors Completion Date: 12/27/10	
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to develop a Plan of Correction (PoC) for an identified problem discovered during a fire drill. Findings include: Review on 10/6/10 of the facility ' s fire drill reports revealed two Residents, at 59 Douglas, refused to evacuate the building during a fire drill held on 4/28/10 at 10:23 AM. The facility did not document a PoC to insure these Residents would evacuate during subsequent fire drills. Interview with administrative staff on 10/7/10 verified no PoC had been developed.	W 449	Plan of Correction for W449 1. The area supervisor/designee will insure any problems that arise during a fire drill will be investigated and documented on a Plan of Correction attached to the Fire Alarm Report. Responsible Person: Area Supervisors Monitor: Area Directors Completion Date: Ongoing 2. The area supervisor/designee will insure their staff are knowledgeable of procedure changes through their staff meetings. Responsible Person: Area Supervisors Monitor: Area Directors Completion Date: 12/27/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, review of written procedures and interviews, it was determined the facility failed to insure nursing staff correctly implemented medication administration procedures. Two of seven nurses were observed not following the facility medication procedures. Findings include: 1. Observation on 10/5/10 at 10:25 AM at Bigfoot [1] revealed that a nurse left the medication cart in the dining room and went to the	W 104		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

11/5/2010

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 104	Continued From page 1 TV/Living room carrying an unlabeled cup and gave the medications in the cup to Sample Resident #7. The nurse did not have a picture of Resident #7 with him and he had initialed the Medication Administration Record (MAR) prior to administering the medication. Review of the facility ' s Nursing Procedures 4.1 and 2.6 on 10/7/10 revealed that nurses administering medication to a resident away from the medication cart must write the resident ' s name on the medication cup, compare the resident ' s picture to the resident, and not initial the MAR until after the medication is administered. Interviews on 10/6/10 and 10/13/10 with the Registered Nurse 4 verified that Nursing Procedures 4.1 and 2.6 are in effect and should have been followed. 2. Observation on 10/7/10 at 8:00 AM at Apple [redacted] of a nurse during medication administration passes to 2 Expanded Sample Residents (#18 and #19) revealed that the nurse did not wear gloves, did not use hand sanitizer, and did not wash her hands. In addition, the nurse spilled medications onto the top of the medication cart, then picked up the medications with her bare fingers and administered the medications to the resident. Review on 10/7/10 of the facility ' s Nursing Procedure 4.1 reveals the nurse is required to change gloves, wash hands, or use hand sanitizer when contaminated and between residents. This procedure also requires that any medications must be disposed of after contacting the surface of the medication cart, which had been contaminated by the nurse and her clothing touching it. Interview on 10/13/10 with the Registered Nurse 4 verified that Nursing Procedure 4.1 is in effect and should have been followed. 3. Observation on 10/7/10 at 9:00 AM at Apple	W 104		

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	50G007	A. BUILDING _____ B. WING _____	10/14/2010

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W 104	Continued From page 2 of a nurse revealed that the nurse left the medication room with unlabeled cups and went into the TV/Living room and administered the medications in those cups to Sample Resident #14 without comparing a picture of the Resident to him. The nurse administered the medications through Resident #14 ' s gastric tube (external tube used to give nutrition and medications to the resident). However, the nurse did not flush the gastric tube with water after the last medication, before starting the Resident ' s liquid feeding. Review on 10/13/10 of the facility ' s Nursing Procedure 6.2 reveals the nurse must always flush the gastric tube with water after administering medications. Nurse Procedure 4.1 requires that nurses administering medications away from the medication cart must write the resident ' s name on the medication cup and compare the resident ' s picture to the resident. Interviews on 10/7/10 and 10/13/10 with the Registered Nurse 4 verified that Nursing Procedures 4.1 and 6.2 are in effect and should have been followed.	W 104		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct fire drills for each house, during each shift, for each quarter of the year. Findings include: Review on 10/6/10 of the facility ' s fire drill reports revealed that 84/85 Sunrise did not document that fire drills had been conducted in October and November of 2009 or July 2010.	W 440		

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W 440	Continued From page 3 Interview with the facility Plant Manager on 10/7/10 verified that those drills had not been documented.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct fire drills at different times of the day. Findings include: Review of the facility ' s fire drill reports on 10/6/10 revealed that all of the facility ' s houses conducted all of the night shift fire drills between the hours of 5:30 AM and 6:30 AM. In addition, 95 Bigfoot, Evergreen and 72/73 Pinewood conducted the afternoon shift fire drills between 3:00 PM and 4:30 PM for all four quarters. Three of four afternoon fire drills for 78/79 Willow were conducted between 3:30 PM and 3:33 PM. Interview with Administrative staff on 10/7/10 verified the drills were conducted during those time frames.	W 441		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to investigate a documented problem that occurred during a fire drill at 59 Douglas. Findings include:	W 448		

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W 448	Continued From page 4 Review on 10/6/10 of the facility ' s fire drill reports for 59 Douglas revealed two Residents refused to evacuate the building during the morning shift fire drill held at 10:23 AM on 4/28/10. Interview with administrative staff on 10/7/10 verified that two Residents refused to evacuate the building and there was no investigation to determine why they refused to evacuate the building or if this was a chronic problem. In addition, the administrative staff revealed there was no facility system in place to insure investigations were conducted following identified problems that arose during fire drills.	W 448		
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to develop a Plan of Correction (PoC) for an identified problem discovered during a fire drill. Findings include: Review on 10/6/10 of the facility ' s fire drill reports revealed two Residents, at 59 Douglas, refused to evacuate the building during a fire drill held on 4/28/10 at 10:23 AM. The facility did not document a PoC to insure these Residents would evacuate during subsequent fire drills. Interview with administrative staff on 10/7/10 verified no PoC had been developed.	W 449		

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	50G007	A. BUILDING _____ B. WING _____	11/04/2011

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W 104	Continued From page 2 missing. The remaining portion of the board had jagged edges which could present a hazard to Residents. Interview on 11/4/11 of Staff #7 revealed Residents use " Frog Hollow ".	W 104		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined 2 of 13 Residents (#5 and #6) did not have a current IMR Quarterly Nursing Health Care Reviews. The Quarterly Nursing Health Care Reviews require a Registered Nurse to physically examine all of a Resident ' s body systems at least every three months and to initiate any actions necessary to address problems found during the examination. Failure to complete the Quarterly Nursing Health Care Reviews may result in failure to promptly detect and treat health care problems a resident may have developed. The facility does not assure adequate staff coverage to enable nurses to address emergent problems, as well as non-emergent preventative and detection tasks, such as the quarterly health care status review. The findings include: Review on 11/3/11 of the records for Resident #5 revealed his most recent IMR Quarterly Nursing Health Care Review was dated 4/12/11. Review on 11/3/11 of the records for Resident #6	W 336	Plan of Correction for W336 1. The quarterly nursing assessments missing for the two cited clients were completed by the assigned RN Team Leader on November 16, 2011. Completion Date: 11/1611 2. The ICF Nursing Supervisor (RN 4) will direct RN Team Leaders to complete assigned quarterly nursing assessments prior to the Quarterly Health Care Reviews and IHP. RN Team Leaders who believe they will need additional time to complete the required quarterly nursing assessments will notify the Nursing Supervisor enough time in advance to request protected time to complete required assessments Once notified, the ICF RN Supervisor will adjust staffing in order to permit the RN Team Leader adequate time to thoroughly assess and complete quarterly nursing assessments. Completion Date: 12/30/11 and ongoing 3. Prior to Quarterly Health Care Reviews, the ICF Nursing Supervisor will verify the quarterly nursing assessments are ready to present at the Quarterly Health Care Reviews. Revisions as needed will be made at the Quarterly Health Care Review. RN Team Leaders will notify the Nursing Supervisor or designee when these have been completed and the assessment is filed in the client record. Using the IHP assessment checklists, the HPAs will notify the ICF Nursing Supervisor of any annual	

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W 336	Continued From page 3 revealed her most recent IMR Quarterly Nursing Health Care Review was dated 1/31/11. Lakeland Village Nursing Procedure 1.4 states that prior to the annual review and quarterly reviews a Registered Nurse Case Manager will complete a Nursing Health Care Review. Interview with the Registered Nurse Team Leader (staff #1) verified she had not completed current health care reviews for Residents #5 and #6 because she was team leader for all the residents of three houses and could not keep current on all quarterly health care status reviews. She states she has too much to do and there are not enough nurses to keep up with everything. The Nurse Manager stated there are supervisory staff vacancies.	W 336	nursing assessments not available for the IHP meeting. Immediate steps will be taken to correct the problem by the ICF Nursing Supervisor with the responsible RN Team Leader which will include completion of the nursing assessment. Completion Date: 12/30/11 and ongoing	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to administer all medications according to the Physician ' s Orders. A facility nurse was observed administering Benefiber (a natural supplemental dietary fiber in powder form which must be ordered by a physician) to Resident #1 on 11/1/11. Review of the Physician ' s Orders and Enteral Order (diet order for someone receiving nutrition via a tube) for Resident #1 revealed there was no order for Benefiber. Interview with the Nurse Manager revealed the facility ' s system for cross-checking and updating Medication Administration Records (MAR) had not caught	W 369	Plan of Correction for W369 1. The RN Supervisors are modifying the facility Nursing Procedure 2.6 "Medication Administration Record" to better reflect and clarify the steps in the verification of orders process. This will include the checking of MARs with the orders by two different nurses. Dietary supplements will also be added to the Enteral Flow Sheets for clients who receive enteral nutrition. The ICF Nursing Supervisor modified the Enteral Flow Sheets by adding a verification line for the nurse who crosschecks the accuracy of the physician's orders to sign as documentation of the review. Upon completion of the revisions to this nursing procedure, RN Supervisors will train nurses on the changes to the procedure and retrain nurses on the full procedure related to the monthly verification of the Medication Administration Records process and the Enteral Flow Sheets. RN Supervisors will provide periodic spot checking (monthly for six months and quarterly thereafter) of Medication	

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W 369	Continued From page 4 this discrepancy. The facility does not have a process to review MARs to assure medications are administered according to Physician's Orders and Enteral Orders. The facility's failure to have a system which insures that all medications are administered according to those orders places Residents at risk of harm. The findings include: On 11/1/11 a facility nurse (Staff #8) was observed administering medications to Resident #1. She gave Resident #1 Benefiber. Review on 11/2/11 of the Physician ' s Orders for Resident #1 revealed there was no order for Benefiber. Interview on 11/2/11 with the facility Nurse Manager (Staff #9) revealed she believed the order for Benefiber should be on the Enteral Order. Review on 11/2/11 of Resident #1 ' s Enteral Order, signed and dated 9/7/11 by the Physician, revealed Benefiber was not listed on it. The Nurse Manager revealed that she believed the order had been mistakenly dropped from the Enteral Order as she verified with the dietician that Benefiber had not been discontinued by the Physician. The Nurse Manager revealed that cross-checking of Physician ' s Orders and Enteral Orders with the MAR at the start of each month is done by any available nurse and there is no set system for doing this verification process. She stated she thought the nurse probably assumed the Benefiber was on the Enteral Order rather than actually checking it. On 11/2/11, the Nurse Manager verified that Benefiber was listed on the MAR but not on the Enteral order, and this had not been caught by the nurse who cross checked the MAR with the Enteral Order.	W 369	Administration Records with Physician Orders to verify accuracy: Completion Date: 1/17/12	
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING	W 381		

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W 381	Continued From page 5 The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the medications at Pinewood House were left unsecured when the medication nurse left the medication room door and medication room cart unlocked and unattended on two different occasions when he left the medication room to administer medications in other sections of the house. The medication nurse could not observe whether anyone else was accessing the medications during these times. Failure to lock the medication cart and/or the medication room door made it possible for Residents to access medications from the medication cart. The facility does not have a system to assure all medications are secured to prevent unauthorized access by Residents and others. The findings include: On 11/2/11 at 7:30 am the medication nurse (Staff #3) was observed during a medication pass observation leaving the medication room with the room door and the medication cart unlocked. The surveyor accompanied the medication nurse while he took medications to administer to Residents in a separate area of the house. The medication room door was out of the sight of the medication nurse. When they returned to the medication room the surveyor informed the medication nurse she had observed they had gone to other sections of the house and he left the medication room door and the medication cart	W 381	Plan of Correction for W381 1. Nursing staff will be retrained by the ICF Nursing Supervisors in LV Nursing Procedure 4.1 "General Principles of Medication Administration" that states in part "Never leave medications unattended. The nurse will lock the medication cart and/or medication room when not in direct visual observation." Nursing Supervisors will also post signs on all medication rooms directing employees to keep the area around the medication room clear and to remind nursing staff to always close and lock the medication room and/or cart when leaving the immediate area. Nursing Supervisors and/or designees will conduct periodic spot checks (at least monthly for six months and quarterly thereafter) to verify medication rooms and/or carts are locked whenever responsible nurse is not in direct visual observation. Completion Date: 1/6/12	

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W 381	Continued From page 6 unlocked. The medication nurse told the surveyor he left the medication room and cart unlocked in case the surveyor needed to look at it. The surveyor reminded the medication nurse she had accompanied him to other sections of the house and did not need or ask for the medication room door and cart to be unlocked. On 11/2/11 at 8:10 am the medication nurse (Staff #3) was observed leaving the medication room to administer medications to Residents in other sections of the house. The surveyor went to the medication room and found, for a second time, that the room door and the medication cart were left unlocked by the medication nurse. The surveyor was doing records review and had not accompanied the medication nurse. The medication room door was out of the sight of the medication nurse. When the medication nurse returned to the medication room the surveyor informed him she had observed he had gone to other sections of the house and he left the medication room door and the medication cart unlocked. The medication nurse told the surveyor he left the medication room and cart unlocked in case the surveyor needed to look at it. The surveyor again told the medication nurse she did not need or ask for the medication room door and cart to be unlocked.	W 381		
W 424	483.470(d)(1) CLIENT BATHROOMS The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients. This STANDARD is not met as evidenced by: Based on observation, record review and	W 424		

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W 424	Continued From page 7 interviews, it was determined the facility failed to insure bathrooms at Douglas and Cascade House had toilet paper that was accessible to Residents at all times. Failure to have toilet paper available and accessible prevents Residents from the opportunity to insure they have good hygiene following toileting. The facility does not have a system to assure residents have consistent and ample availability of necessary supplies. The findings include: 1. Observations at 59 Douglas on 10/31/11 at 2:15 pm 11/1/11 at 11:00 am revealed the two south bathrooms did not have toilet paper in the dispensers. Observations at 59 Douglas of the north bathroom on 10/31/11 at 2:15 pm, 11/1/11 at 11:00 am, and 11/2/11 at 10:20 am revealed the toilet paper was on a rack holding latex gloves which was on the wall opposite the toilet making it inaccessible from the toilet. Interview on 11/2/11 with the Attendant Counselor Manager (Staff #10) revealed the house has Residents who use a lot of toilet paper and the staff need to check it frequently. 2. Observations of two bathrooms at Cascade house on 11/1/11 and 11/2/11 revealed the toilet paper dispenser in one of the bathrooms was designed to dispense toilet paper in single sheets. During both observations the dispenser was full but the surveyor was not able to get the paper out when checking to see if it was readily accessible. Interview with a direct care staff on 11/3/11 confirmed Residents used the toilet where the single sheet dispenser was and understood the toilet paper was difficult to get out of the dispenser.	W 424	Plan of Correction for W424 1. The post schedules on each living unit will be updated by the AC Manager to assure that the designated shift charge check every bathroom at least once per shift to assure there is an adequate supply of accessible toilet paper. Additionally, all staff assisting clients using restrooms will assure there is an adequate supply of accessible toilet paper available in the restroom. Completion Date: 12/30/11 and ongoing 2. The IDT including the assigned HPA, AC Manager and others will review toileting programs for individuals who have a need to learn how to use toilet paper appropriately and will identify the best way to address these needs. Completion Date: 12/30/11 and ongoing	
W 440	483.470(i)(1) EVACUATION DRILLS	W 440		

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W 440	Continued From page 8 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on observations, interview and record review, it was determined the facility failed to insure quarterly fire drills were held for 6 of 9 houses (Hillside, Apple, Wildrose, Willow, Evergreen, Douglas). Failure to hold fire drills as required prevents staff and Residents from learning how to safely evacuate the building and could put them at risk of injury or harm. The facility's system for checking to insure fire drill documentation was present failed to identify the missing fire drills. Review on 11/1/11 of the facility ' s annual fire drill records revealed documentation was missing for third quarter for Hillside night shift, Apple day shift, Wildrose day shift, Evergreen night shift, Douglas day shift and for the second quarter for Willow afternoon shift. Interview with the Developmental Disabilities Administrator (DDA) I and the Fire Marshal on 11/3/11 confirmed there was no documentation the fire drills had been held.	W 440	Plan of Correction for W440 1. The online Fire Drill log containing fire drill records was color coded by Computer Services staff on November 22, 2011 to help supervisors (AC Managers, Adult Programs Supervisor and ICF PAT Director) determine that required drills are completed. AC Managers will follow LV Procedure 9.2 "Fire Drills" ensuring each shift holds a quarterly fire drill and will provide documentation to the Front Desk Switchboard Operator for the Dire Drill log. The ICF PAT Director will review the fire drill log to check for completion of all required drills within the quarter. This will occur within a time period sufficient for any remaining drills not yet completed to be held within the quarter the fire drill is due. The AC Manager and other area supervisors will provide both the Front Desk Switchboard Operator and the Cabinet level manager (PAT Director, Nursing Home Administrator, Facility Services Manager) documentation to show the drill was completed within the required time period. Completion Date: 12/27/11 and ongoing	

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

- Rainier School PAT A SODs 2015 – 2010

Note: There is no SOD for 2014 due to the interval of surveys completed between December 2013 and March 2015.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

April 3, 2015

BY FACSIMILE and CERTIFIED MAIL (7007 1490 0003 4195 0178)

Important Notice – Please Read Carefully

Alan McLaughlin, Superintendent
Rainier School PAT A
PO Box 600
Buckley, Washington 98321

RE: Annual Recertification Survey 3/2/2015 through 3/11/2015

Dear Mr. McLaughlin:

From 3/2/2015 through 3/11/2015 survey staff from the Residential Care Services (RCS) Division of the Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey and complaint investigation at your facility. Based on that survey, RCS determined that Rainier School PAT A is out of compliance with federal condition of participation (CoP) requirements for ICFs/IID participating in the Medicaid Title XIX ICF/IID program. Compliance with all CoPs, found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The survey completed on 3/11/2015, found that Rainier School PAT A failed to comply with the following CoPs:

W102 – 42 CFR 483.410 Governing Body

Specifically, the following governing body requirements were found not met:

W104 - CFR 483.410 (a) (1) exercise general operating direction over the facility.

W122 – 42 CFR 483.420 Client Protections

Specifically, the following client protection requirements were found not met:

W125 - CFR 483. 420(a) (1) exercise rights as clients and citizens,
W128 - CFR 483. 420 (a) (6) free from unnecessary drugs and restraints,
W149 - CFR 483. 420 (d) (1) develop and implement policies prohibiting neglect

All references to regulatroy requirements contained in this letter are found in Title 42, CFR and the Center for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) concerning provider certification.

W153 - CFR 483.420 (d) (2) allegations reported immediately
W154 - CFR 483. 420 (d) (3) alleged violations are thoroughly investigated
W155 - CFR 483. 420 (d) (3) abuse prevented while investigating and
W157 - CFR 483. 420 (d) (4) take appropriate action if the allegation is verified.

W195 – 42 CFR 483.440 Active Treatment

Specifically, the following active treatment requirements were found not met:

W196 - CFR 483.440 (a) (1) each client receives active treatment.
W247 - CFR 483.440 (c) (6) (vi) client choice and self management and
W249 - CFR 483.440 (d) (1) implementation of the program.

The deficiencies are described in CMS Form 2567, a copy of which is attached. The cited deficiencies indicate limitations in Rainier School PAT A capacity to provide adequate operating direction, active treatment and protection of residents. Significant corrections will be required before the facility can be found to be in compliance.

Remedy
Substantial compliance with federal requirements must be achieved and verified by 6/9/2015 (90 days from the date on which the survey was completed (SOM 3012)). Failure to achieve substantial compliance with 42 CFR 483.410 Governing Body, 42 CFR 483.420 Client Protections, and 42 CFR 483.440 Active Treatment may result in termination from the Medicaid ICF/IID program (42 CFR 442.101 (3) (e); SOM 3005 E).

Alternate Remedy
In lieu of termination from the Medicaid program, the State Medicaid Agency (SMA) may choose to impose a Denial of Payments for New Admissions (42 CFR 442.118; SOM 3006). If the SMA chooses to impose the denial of payment remedy, you will be notified on or before the 60th day (5/10/2015), and will be advised of any appeal rights at that time.

Plan of Correction (PoC)
At this time you may **voluntarily** submit a PoC, however, the PoC will not halt the termination proceedings. The department will proceed with termination until you have achieved substantial compliance with the Conditions of Participation (CoPs). The CoPs must be verified on-site by RCS as substantially implemented by 6/9/2015. At the time you achieve substantial compliance with the CoPs, you will be required to submit an acceptable PoC for any remaining standard level deficiencies. If and when you do submit a PoC, it must be approved by RCS.

An acceptable PoC must contain at a minimum the following core elements (SOM 3006.5C):

1. How the corrective action will be accomplished for the sample Individuals found to have been affected by the deficient practice;

2. How the facility will identify other Individuals who have the potential to be affected by the same deficient practice, and how it will act to protect Individuals in similar situations;

3. What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;

4. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and

5. When corrective action will be accomplished.

Additionally we request that you include the title of the person responsible to ensure correction.

Allegation of Compliance

When you believe the CoP deficiencies have been corrected, please provide the ICF/IID Field Manager with a written credible allegation of compliance. The credible allegation should address the deficiencies cited under 42 CFR 483.410 - W102 Governing Body, 42 CFR 483.420 - W122 Client Protections, and 42 CFR 483.440 - W195 Active Treatment. The letter should describe: (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur.

If Rainier School PAT A makes a credible allegation of compliance, the ICF/IID survey team will revisit to determine whether compliance or acceptable progress has been achieved. Only two revisits are permitted, one no later than 4/25/2015 (within 45 days of the date on which the survey was completed), and one between 4/26/2015 and 6/9/2015 (between the 46th and 90th days (SOM 3012)). The compliance decision by RCS needs to be finalized no later than 6/9/2015 (90th day). RCS will require at least five working days to complete a credible allegation survey and make a decision regarding compliance. Please plan accordingly if you want RCS to be able to complete a credible allegation survey before 6/9/2015 (90th day).

If upon the subsequent revisit, your facility has not achieved substantial compliance, the termination or denial of payment for new admissions will be imposed. A revisit will not be conducted if a letter of credible allegation is not received by RCS. The CoP will need to be found to be in substantial compliance before certification can be continued.

Informal Dispute Resolution (IDR)

You may request an IDR of the deficiencies on which this action is based. RCS must receive your request for an IDR no later than 4/13/2015. To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a written credible allegation of compliance within the time limits described above. The written IDR request should:

1) Identify the specific deficiencies that are disputed;
2) Eplain why you are disputing the deficiencies; and
3) Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review)

If requested, an IDR will be scheduled. During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. The IDR process will not change the time frames stated in this letter, including the deadlines for achieving compliance and submitting a written credible allegation of compliance.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services

Enclosure

cc: CMS Regional Office, Washington State ICF/IID Team
Bill Moss, Assistant Secretary of ALTSA
Carl I. Walters II, Director of RCS
Donna Cobb, Senior Counsel
Evelyn Perez, Assistant Secretary of DDA
Donald Clintsman, Deputy Assistant Secretary of DDA
Janet Adams, DDA Office Chief
Larita Paulsen, DDA QM Unit Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G050	A. BUILDING _____ B. WING _____	03/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of an annual recertification survey conducted between 3/2/15 and 3/11/ 15. In addition , complaint investigations were conducted for the following: #3068033, #3079747, #3033611, #3032445, # 3021326, #3075422, #3074874, #3017359 and #3074594. The team consisted of the following surveyors: Kathy Heinz, Marci Caird, Gerald Heilinger, Claudia Baetge and Jim Tarr. A sample of 12 residents was drawn from a census of 112. The team expanded the sample to include 30 additional residents. The Survey Team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long Term Care Administration Department of Social and Health Services PO Box 45600 Olympia, WA 98504-5600 Telephone: 360-725-2405 Fax: 360- 725-2642	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and interview the facility failed to meet the Condition of Participation in Governing Body by not exercising operating direction over the facility and by not meeting the Condition of Participation for	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1 Active Treatment and The Condition of Participation for Client Protections. Findings include: The governing body failed to exercise general operating direction in a manner that resulted in: 1. The facility did not ensure there were adequate risk benefit analysis for the use of restraints, there were adequate policies addressing the use of chair restraints, or there were plans to reduce the use of the restraints. The facility did not ensure alarms were used only when there was a need . The facility did not ensure the human rights committee and guardians authorizing the use of the restraints fully understood all the risks and benefits associated with the use of the restraints. The facility did not ensure that residents sitting for long periods of time in restraints were checked and monitored for safety, or that residents were not subjected to alarms going off throughout the day. See W104 2. The facility did not meet the Condition of Participation for Active Treatment Services by not developing and implementing plans based on functional assessment, by not promoting self-management and by not ensuring adequate staffing to meet resident need. See W195 3. The facility did not meet the Condition of Participation for Client protections when it failed to protect resident rights', failed to ensure residents were free from restraints and were protected from staff neglect. The facility failed to ensure allegations were reported in a timely manner, residents were protected from further abuse and failed to thoroughly investigate a significant injury of unknown origin. The facility did not ensure corrective actions they identified were completed. See W 122	W 102		

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W 104	Continued From page 2	W 104		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure there were adequate risk benefit analysis for the use of restraints, there were adequate policies addressing the use of dining room chair restraints, alarms were only used when needed, and there were plans to reduce the use of restraints. This failure affected five Sampled Residents (Resident #1, #4, #6, #7 #12) and eight Expanded Sampled Residents (Residents #22, #27, #29, #31, #32, #33, #34, #35). This failure resulted in the human rights committee and guardians authorizing the use of the restraints without fully understanding all the risks and benefits, residents sitting for long periods of time in restraints without staff checking the Residents ' health and safety, and homes with alarms going off throughout the day without any need. Findings include: Risk/Benefit Analysis Resident #4 Review on 3/6/15 of Resident #4 ' s Individual Habilitation Plan (IHP) dated 2/6/15 revealed the following items were designated as restrictive: gait belt, Attends, chest and waist supports on toilet, wheelchair with (tilt in space) safety belt, ankle huggers and foot straps, hospital bed with padded siderails with head of bed elevated, and standing frame. The only risk identified for these devices was: " [Resident #4 ' s name] right to freedom of independent movement will be	W 104		

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W 104	Continued From page 3 abridged " . Interview on 3/10/15 with Staff CC verified there was no other explanation of risks associated with each of the restrictive components of Resident #4 ' s plan. Resident #12 Review on 3/9/15 of Resident #12 ' s IHP dated 7/15/14 revealed the following items were designated as restrictive: protective cover, incontinence briefs, bed bath and freedom tub with harness, foot/ankle orthotics, low bed with scoop mattress, recliner/couch/sensory room chairs all with seatbelt, and mechanical lift and sling. The only risk identified for these devices was: " [Resident #12 ' s name] right to freedom of independent movement will be abridged " . Interview on 3/10/15 with Staff YY verified there was no other explanation of risks associated with each of the restrictive components of Resident #12 ' s plan. Dining Room Chair Restraints Resident #6 Observation at Buckley House on 3/4/15 between 9: 45 AM and 11:30 AM revealed Resident #6 was sitting at the dining room table with a seatbelt fastened around her chest. There was a large Connect Four game in front of her. At 11:30 AM staff filled the "Connect Four" game with large plastic circles, removed the game from the table and served lunch. Resident #6 sat restrained to the dining room chair for 1 and 1/2 hours prior to lunch being served. At no time did staff check the restraint to ensure it was not too snug or if it was placed properly. At no time did staff ask Resident #6 if she wanted to sit somewhere else or if she was comfortable. Observation on 3/5/15 at Buckley house between 7: 10 AM and 8:12 AM revealed Resident #6 was sitting in a dining room area of the home. There was seat belt buckled around the middle of her	W 104		

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W 104	Continued From page 4 chest. At 7:48 AM, staff pushed Resident #6's chair up to the table. At 8:12 AM, a staff served Resident #6 her breakfast. Resident #6 sat in the dining chair for 62 minutes before she ate breakfast. Review of Resident #6 ' s Individual Habilitation Plan dated 7/14/14 revealed under the section titled adaptive equipment and mechanical supports, Resident #6 had a chest support on her dining room chair. The plan indicated it was used only when resident #6 was eating. Review of the facility policy Standard Operating Procedure (SOP) 3.1 titled Adaptive Equipment and Mechanical Restraints revealed there are no policies addressing the maximum amount of time a resident should be left in a dining room chair restraint or how often a resident should be checked by staff while restrained in a dining room chair. Interview with Staff Q on 3/10/15 revealed the facility did not consider dining room chair seatbelts as restraints. The seatbelts were considered mechanical supports. Alarms Observation of Percival House on 3/3/15 in the dining room at 9:33 AM revealed an alarm began sounding. It was loud and intrusive. It did not appear that staff responded to the alarm which was located on the wall. Interview with Staff D revealed the alarm was for Resident #31 and that it was to alert staff when Resident #31 was out of his bed. Staff D further revealed she did not respond to the alarm because she knew a staff was making Resident #31 ' s bed at that time. Observation on 3/5/15 of Percival House in the dining room at 7:10 AM revealed the same alarm went off and again no staff responded. Interview with Staff D revealed she did not respond to the alarm as she knew Resident #31 was up and out	W 104		

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W 104	Continued From page 5 of his room at that time. Observation on 3/3/15 of Percival House between 3:45 PM and 3:53 PM revealed the following Residents ' alarms went off when the State Surveyor walked into the room for Residents #32, #33, #34, and #35. Each of the alarms sounded in the dining room area of the side of the house they lived on except Resident #34 ' s which sounded in the dining room on the opposite side of the house from where his bedroom was located. Interview on 3/3/15 with Staff K revealed the alarms are not turned off during the day. She verified the alarms were only needed for when the Residents were in bed, which was usually at night. Observation on Devenish house on 3/6/15 at 11:00 AM revealed motion sensor alarms in bedrooms for the following residents: Resident #7, #22, #27, #29 and #1. The motion sensor alarm made a different sound for each resident. When staff or residents were within range of the motion sensor the alarm sounded. The sound was audible throughout the house during all hours of the day. The two main sensor alarm boxes sounded in the living room of the A and B side of the house. The alarm on the A side of the house was for: Resident #22, #1, #29 and on the B side of the house: Resident #7 and #27. Record review of Individual Habilitation Plans (IHPs) revealed a Motion Sensor schedule for use as follows: IHP dated 11/13/14 for Resident #7 scheduled during sleep hours; IHP dated 3/4/14 for Resident #1 scheduled during sleep hours; IHP dated 9/18/14 for Resident #29 scheduled during sleep hours; IHP dated 8/5/14 for Resident #27 scheduled during sleep hours; IHP dated 4/15/14 for Resident # 22 scheduled for whenever in bed. Interview with Staff S on 3/10/15 at 3:00 PM acknowledged the sensor alarms were on 24	W 104		

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W 104	Continued From page 6 hours a day 7 days a week which conflicted with Individual Habilitation Plans of being on only during sleep hours or whenever in bed. Interview with Staff CC on 3/9/15 at 9:30 AM acknowledged the sensor alarms were for night time use only.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure resident rights' were protected, residents were free from restraints and were protected from staff neglect. The facility failed to ensure allegations were reported in a timely manner, residents were protected from further abuse and a significant injury of unknown origin was investigated thoroughly. The facility failed to ensure corrective actions based on investigative results were completed. Failure to ensure residents rights were protected resulted in residents being restrained for long periods of time, the right to privacy and an unobstructed view abridged without justification, allegations not being reported timely and a significant injury not being thoroughly investigated. See W125, W128, W149, W153, W-154, W155 and W157.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients	W 125		

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W 125	Continued From page 7 of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure the rights of three Sampled Residents (#1, #3 and #7) and 12 Expanded Sampled Residents (#13, #14, #15 #22 #26 #27 #37 #38 #39 #40 #41 #43) were protected when they obstructed the views from bedroom windows and displayed resident pictures and dietary restrictions in public areas. This failure resulted in residents ' personal privacy not being protected and resulted in the residents ' not having the abilities to make informed decisions regarding their rights to privacy and rights to look out through their bedroom windows. Findings include: 1. Observation on Devenish House on 3/3/2015 at 9:00 AM revealed a hutch in the dining room areas of the A and B side of the house that displayed Residents ' photo dietary cards visible to all guests/visitors for: Residents #1,#7, #22, #26, #27 #37, #38, #39, #40, #41 #43. Record review of IHP Guardian/Family Response/Assessment Form for Resident #7, the guardian checked ' No, I do not agree to photographs, use of first name (only) and art work may be published in Facilities newsletter or on bulletin boards at facility '. Interview with Staff S on 3/10/15 at 11:00 AM acknowledged privacy concerns with displaying the residents ' photos and dietary cards and indicated that facility care staff do have a binder available with all dietary recommendations/restrictions.	W 125		

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W 125	Continued From page 8 2. Observation on Devenish on 3/04/15 at 10:25 AM revealed Resident #15 ' s bedroom window was missing privacy curtains. Interview with Staff Z on 3/04/15 at 10:25 AM acknowledged Resident # 15 will pull any curtains down and the exterior shade was placed to provide privacy. Outside of Resident #15 ' s bedroom window on the exterior of the house was a shade hanging approximately 2 feet from the window that blocked Resident #15 ' s ability to look out his bedroom window. When standing outside of the house, between the shade and window anyone could view inside Resident 15 ' s bedroom. Interview with Staff S on 3-10-15 at 11:0 AM acknowledged Resident #15 ' s ability to look outside was blocked by the window shade. 3. Observation made at Haddon House on 3/3/15 at 2:59 PM and 3/4/15 at 10:35 AM found the facility had hung shades from the eaves of the roof outside the bedroom window for Residents #3 and #13 (who shared a bedroom) as well as the bedroom window of Resident #14. A full view of the outside from inside each bedroom was obstructed. In addition, the shades were hung in such a manner that allowed a space for someone to stand off to the side or between the shade and the window and look directly into the bedroom of each Resident. Staff VV was interviewed on 3/4/15 at 10:35 AM and reported the shades were used because drapes would get pulled down and two of the Residents (#13 and #14) liked to be naked in their bedrooms. Review of Individual Habilitation Plan records on 3/10/15 for Resident # 3 dated 9/16/14, Resident #13 dated 5/27/14 and Resident #14 dated 10/7/14 revealed the use of the shades were not addressed.	W 125		

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W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure one of 12 Sampled Resident (#6) and one of one Expanded Sampled Residents (#30) were free from physical restraints. This failure resulted in residents being confined by restraints while on the toilet, in a recliner or while seated in a dining room chair for long periods of time. Findings include: Resident #6 Resident #6 was observed between 3/2/15 and 3/11/15 restrained by a seatbelt that was attached to a living room chair, restrained by a seat belt that was attached to a dining room chair 1. Observation on 3/2/15 at Buckley House at 10:55 AM revealed Resident #6 was sitting in a large overstuffed chair. There was a seatbelt attached to the chair. Resident #6 was buckled in the chair. At 11:11 AM Staff M assisted Resident #6 into a wheelchair and fastened the seatbelt. Staff M pushed the wheelchair into the dining room and assisted Resident #6 into a dining room chair and fastened a seatbelt around her waist. At 11:20 Staff R pushed resident #6's chair to the dining room table and placed a clothing protector around her neck. 2. Observation on 3/3/15 at Buckley House 3:34 PM revealed Resident #6 was sitting in a recliner	W 128		

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W 128	Continued From page 10 in the living area of the home. There was a seatbelt strapped across her waist. At 4: 15 PM Staff M assisted Resident #6 from the easy chair into a wheelchair and buckled her in. Staff M then took Resident #6 into the dining room, assisted her to the dining room chair and buckled her in. 3. Observation on 3/5/15 at Buckley house between 7: 10 AM and 8:12 AM revealed Resident #6 was sitting in a dining room chair approximately two feet away from the dining room table. There was a seat belt buckled around the middle of her chest. At 7:48 AM, staff pushed Resident #6's chair up to the table. Resident #6 sat restrained in the dining chair for 62 minutes before she ate breakfast at 8:12 AM. No staff asked her if she wanted to sit anywhere else or if she was comfortable. 4. Observation on 3/3/15 at 5:15 to 5:45 PM revealed Resident #6 was sitting in the living area of the home in a recliner with a seatbelt across her lap. She appeared to be sleeping. Record review on 3/9/15 of Resident #6's Individual Habilitation Plan (IHP) dated 7/14/14 revealed the dining room chair restraint was supposed to be applied only when Resident #6 was eating. Interview with Staff M revealed Resident #6 needed to be restrained because she is a fall risk. Interview with Staff N 3/6/15 on revealed the Occupation Therapy Department is looking at the use of all the restraints used at the facility and identifying ways to reduce the use of them. Interview with Staff Q on 3/11/15 regarding the use of the restraints in dining room chairs revealed the facility uses the seat belts that are attached to the dining room chairs as "positioning devices" and should only be used when eating. Resident #30 Observation on 3/5/15 at Buckley House revealed	W 128		

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W 128	Continued From page 11 an Adult Training Program (ATP) took Resident #30 into the bathroom at 7:50 AM. The ATP staff came out of the bathroom. The ATP staff started assisting other residents to eat breakfast. At 8:17 AM, the surveyor asked the ATP staff to produce the toilet support log for Resident #30 as no one had checked on Resident #30. The ATP staff went into the bathroom Resident #30 was sitting in and gave the restraint log to the surveyor. Review of the record revealed the ATP staff had not entered the time she assisted Resident #30 to the toilet. Resident #30 sat, restrained on the toilet for 27 minutes until the surveyor intervened. Review of the hourly toilet support log for 3/5/15 revealed no documentation when Resident #30 was put on the toilet or when she had been checked or monitored. Review of the facility's policy title Standard Operating Procedure (SOP) 3.13 revealed residents placed in a "Toilet Support" device will be monitored at a minimum of every ten minutes. Interview with Staff M revealed Resident #30 needed to be kept on the toilet until staff could assist her to clean herself properly.	W 128		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to implement facility procedures to ensure that three of three Expanded Sampled Residents (Residents #18, #19, and #20) were protected from neglect. Resident #18 was left	W 149		

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W 149	Continued From page 12 unattended for an extended period of time in a bed bath trolley, Resident #19 was left with an alleged perpetrator after an allegation of abuse was made and Resident #20 did not receive medication as prescribed. These failures placed residents at risk for potential harm. Findings include: 1. Review on 3/3/15 of a facility investigation into an incident which occurred on 7/13/14 revealed Resident #18 had been left on a bed/bath trolley for a minimum of 2 hours and possible up to 3 ½ hours after a medical procedure was completed. Resident #18 had been placed on the trolley in preparation for a medical procedure. Resident #18 was not attended to during the time she was on the trolley and was not repositioned every 2 hours as required by her plan. Resident #18 was not able to move off of the trolley independently. Interview on 3/5/15 with Staff A verified Resident #18 should not have been left on the trolley unattended. 2. On 3/9/15 the State Survey Team was notified of an incident of alleged abuse against Resident #19 which occurred on 3/6/15. The facility incident report revealed Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19 ' s bare feet and pulling him up to a standing position. The incident was observed by Staff H and Staff U. Only Staff U told Staff B to stop and that it was not an appropriate way to treat Resident #19. Staff U reported Staff B stated Resident #19 liked being kicked and Staff U reported Staff H agreed Resident #19 liked being kicked. However, Staff U did not prevent Staff B from continuing to interact with Resident #19 and allowed Staff B to take Resident #19 into the bathroom behind a closed door.	W 149		

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W 149	Continued From page 13 3. A review on 2/18/15 of a facility incident report revealed Staff PP failed to administer a prescribed medication, Fenofibrate, to Resident #20 on 12/17/14 and 12/18/14.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure four of four allegations of abuse, neglect, or mistreatment (Expanded Sampled Residents #18, #19, #21 and #22) were reported to the facility in a timely manner. In each instance, facility staff delayed their report to the facility. This failure prevented the facility from ensuring Residents were protected and from beginning an immediate investigation into the allegation. Findings include: 1. Review on 3/3/15 of a facility investigation of an incident which occurred on 7/13/14 revealed Resident #18 had been left on a bed/bath trolley for a minimum of 2 hours and possible up to 3 ½ hours. Resident #18 had been placed on the trolley in preparation for a medical procedure that had Physician ' s orders to occur at 7:00 AM. Resident #18 was not attended to during the time she was on the trolley and was not repositioned every 2 hours as required by her plan. Resident #18 was not able to move off of the trolley independently. Resident #18 was found on the	W 153		

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W 153	Continued From page 14 trolley by Staff V at approximately 2:20 PM. Staff V did not report this incident to the facility until 11:10 PM of the same day. Interview with Staff A on 3/5/15 verified staff reported the incident late. 2. On 3/6/15 at approximately 2:05 PM, Staff U observed an incident of alleged abuse against Resident #19. Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19 ' s bare feet and pulling him up to a standing position. Staff U did not report this incident to the facility until 2:25 PM. Interview with Staff T on 3/9/15 verified there was a delay in reporting. 3. Review on 3/3/15 of a facility incident report and investigation revealed on 8/4/14 Staff W observed Staff X push a chair into a dining room table, where Resident #21 was seated eating dinner that caused the table to rotate 60 degrees from its original position. Staff W was upset by this action and thought this was inappropriate. This incident occurred at approximately 5:00 PM but Staff W did not report this incident to the facility until the next day. Interview with Staff T on 3/9/15 verified there was a delay in reporting. 4. Review on 3/10/15 of a facility incident report and investigation revealed on 6/5/14 at 3:15 PM Staff AAA discovered a narcotic medication (1 tablet of 300 mg [redacted] (seizure medication) for Resident #22 that remained in the medication drawer. Staff BBB also discovered the 8:00 AM medications: Calcium with Vitamin D, [redacted] for Resident #22 had not been signed off as administered and notified Staff AA. Staff AA did not report this incident until 6/10/2014 following completion of facility internal investigation.	W 153		

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W 153	Continued From page 15 Interview with Staff AA on 2/18/15 verified the medication errors occurred prior to the completion of the correction action.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to thoroughly investigate a significant injury of unknown origin for Resident #23 who had a fractured [redacted] Failure of the facility to investigate significant injury may result in the facility not knowing what happened and thus not being able to rule out abuse and neglect or take appropriate corrective action. Findings include: Review on 3/2/15 of a facility investigation dated 9/25/14 revealed Resident #23 was making "angry faces" and had refused to participate in occupational therapy at approximately 2:00 PM in the afternoon. It was determined through an X-ray that Resident #23 had a comminuted (pulverized) [redacted] fracture of the [redacted] Interview with Staff NN regarding the incident on 3/6/15, with the facility investigation record present, revealed when she examined Resident #23's [redacted] she noted the abrasions were recent. The physician note dated 9/25/14 revealed: obvious linear abrasions/acute contusion/bruising over [redacted] The facility investigator concluded that Resident #23 walked freely about the house and most likely hit her [redacted] on the metal door frame of the bathroom. The witness statements prepared by	W 154		

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W 154	Continued From page 16 Staff B, H and I did not include information that would help determine when or where the injury might have occurred. Staff did not indicate when they last saw Resident #23. Review of the facility's post position scheduled revealed Staff B was assigned to work with Resident #23 the day the injury was discovered. Staff B wrote in his witness statement: "was sitting next to Resident #23 in her chair and she started making angry faces and I was holding her right arm." Staff B wrote he had cued Resident #23 to go to the bathroom and get ready for the day." Staff B wrote "morning activities of daily living went fine and upon ADL's I didn't notice anything that looks like a bruise." Staff B indicated Resident #23's movements throughout the day seemed normal. The witness statement dated 9/25/14 for Staff H revealed he was working the day the injury was discovered, he wrote: "unknown fall or ran into something shoulder height." The witness statement dated 9/25/14 for Staff I revealed she wrote: "Possible fall or door jamb." The facility investigation did not indicate the physician was interviewed about the injury, if Resident #23 was unsteady on her feet or if staff were working their post positions as assigned. Interview on 3/6/15 with Staff T revealed Resident #23 would not have been able to get up by herself if she had fallen. The facility investigation revealed that under the section titled: follow up and plan of correction, the box was marked "no." However, on 9/26/14 an AD HOC was held and it was determined a sensor would be placed by Resident #23's bed to alert staff if Resident #23 got out of bed. On 11/25/14, Resident #23 fell off the toilet and fractured her [redacted]	W 154		

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W 155	Continued From page 17	W 155		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to protect residents when they allowed two staff that were implicated in an incident of alleged abuse to continue to work, and also allowed another staff to continue to administer medications to residents before the corrective action from an earlier medication error had been completed. Failure of the facility to implement protective measures when staff are accused of neglect or abuse may place residents at risk of further neglect and abuse. Findings include: 1. On 3/6/15 at approximately 2:05 PM, Staff U observed an incident of alleged abuse against Resident #19. Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19 ' s bare feet and pulling him up to a standing position. This incident was reported by Staff U and was also witnessed by Staff H. State Surveyors observed Staff U working with residents after the incident had been reported. No measures to protect Residents from Staff U or Staff H had been taken by 3/9/15. Interview with Staff A on 3/9/15 revealed the facility was not aware of Staff H ' s involvement in the incident 2. Review of a facility investigation dated 12/9/14 Staff PP was alleged to have made a medication error when she failed to give Resident #43 a medication ([redacted]). The facility conducted an investigation of the error and on 12/22/14,	W 155		

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W 155	Continued From page 18 Staff PP received an oral reprimand from Staff AA and a Performance Meeting Record was written. However, prior to the completion of this corrective action process Staff PP was allowed to continue to administer medications and committed two more medication errors when she failed to give Resident #20 a prescribed medication [redacted] on both 12/17/14 and 12/18/14. Interview with Staff AA on 2/18/15 verified the medication errors occured prior to the completion of the correction action.	W 155		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to put padding on the headboard for one Expanded Sampled Resident (Resident #24), failed to follow up on an Occupational Therapy visit for one Expanded Sampled Resident (Resident #25), allowed staff to administer medication to Expanded Sampled Resident (Resident#20) prior to completion of a Plan of Correction from a previous medication error, and did not follow the recommendation that a cushion tube be placed over a belt buckle of one Expanded Sampled Resident (Resident #28). These failures placed residents at risk for further injuries. Findings include: 1. Observation on 3/3/15 at 7:42 AM of Resident #24 ' s bedroom found no padded headboard in use. Record review on 3/10/15 at 2:30 PM of an	W 157		

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W 157	Continued From page 19 Incident Report (IR) revealed on 2/6/15, Resident #24 had a bruise and abrasion on the right side of her forehead. Record review on 3/10/15 at 2:30 PM of the facility ' s investigation report found staff believed the injury was caused by Resident #24 ' s headboard. The investigation report also stated on 10/25/13 Resident #24 hit her head on her headboard causing an injury. Per the investigation report, the interdisciplinary team (IDT) discussed the current incident at the 2/12/15 house meeting and decided at that time a referral should be done for assessing Resident #24 ' s bed for padding. Record review on 3/10/15 at 8:55 AM of Work Request #00087237 found the request for padding the headboard of Resident #24 ' s headboard. This Work Request had the requested priority of " URGENT. " During an interview on 3/3/15 at 8:55 AM with Staff EE, he stated PT (Physical Therapy) or OT (Occupational Therapy) were supposed to evaluate Resident #24 ' s headboard for the possibility of using a padded headboard. He did not know if that had been done yet. He also said the evaluation was to be done as a result of an incident report from awhile back where staff thought Resident #24 hit her head on her headboard. Interview on 3/10/15 at 8:50 AM with Staff LL in the maintenance office revealed the maintenance shop had not received the work order for Resident #24 ' s padded headboard. He was able to track the work request via computer and stated the PAT A director signed off on the work order on 2/27/15 but it was still waiting for a signature from the Assistant Superintendent before his office could receive it. An interview on 3/10/15 at 11:25 AM with Staff N	W 157		

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W 157	Continued From page 20 revealed the OT department submitted a work order to pad Resident #24 ' s headboard to prevent any further injury. During an interview on 3/10/15 at 11:25 with Staff A, she stated there are two work order priority levels, urgent and regular. She said the urgent orders are taken care of first. While the surveyor was present, Staff A called Staff LL and asked for status of the work request. She then telephoned Staff MM and reported to the surveyor that Staff MM would approve the work request today. 2. Observation on 3/4/15 at 10:28 AM of Resident #25 found her sitting in an adaptive chair leaning to her right side. Record review on 3/2/15 at 2:00 PM of a facility investigation found on 2/8/15, Resident #25 was discovered to have a bruise which facility staff determined was caused by Resident #25 ' s adaptive dining chair. Record review on 3/2/15 at 2:15 pm of Resident #25 ' s Occupational Therapy (OT) notes found on 2/27/15 the OT department assessed the named resident ' s leaning when in her adaptive dining chair. The note stated " PT to consult next week. " Record review on 3/6/15 at 9:22 AM of Health Interdisciplinary Notes revealed a note written by a physician ' s assistant on 2/26/15 requesting follow-up for Resident #25 in the clinic in one week to evaluate and consider possible physical therapy options. The resident ' s primary care physician, Staff NN, signed in agreement of this plan the same day, 2/26/15. Record review on 3/6/15 at 9:25 AM of the physician ' s orders for 2/26/15 found no orders written for the follow up appointment as indicated in the Health Interdisciplinary Notes. During an interview on 3/6/15 at 10:28 with Staff OO she stated Staff NN appeared to agree with	W 157		

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W 157	Continued From page 21 the physician ' s assistant on the Health Interdisciplinary Notes, but it did not get written on the physician ' s order. She said she would follow up with it. There was no documentation showing Resident #25 was taken to the clinic to consult for possible physical therapy options. 3. A review of an Incident Report date 12/19/14 obtained from the facility on 2/18/15 found that Resident #20 was not given a prescribed medication ([redacted] on 12/17/14 and 12/18/14 by Staff PP. A record review of a 5 Day Investigation Report dated 12/22/14 revealed that Staff PP had an extensive history of medication errors as detailed below: 1. Six medication errors or omissions in 2014 2. Two medication errors or omissions in 2013 3. Four medication errors or omissions in 2012 4. Three medication errors or omissions in 2011 The corrective actions taken by the facility regarding Staff PP ' s medication errors ranged from Performance Meetings, Letters of Expectations, oral reprimands and re-training. On 2/19/15 Staff PP received a Letter of reprimand from the facility for the medication errors for 12/17/14 and 12/18/14. The facility ' s corrective actions did not appear to be effective as the staff continued to make medication administration errors. The facility failed to protect the resident when it failed to look at patterns, frequency, and history of medications errors. The facility ' s Standard Operating Procedure 4.14 Medication Errors states " there is no acceptable incident rate for medication errors: " Interviews with Staff AA and Staff # QQ on 2/18/15 revealed that when investigating medication errors the facility looked at adverse	W 157		

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W 157	Continued From page 22 outcomes, severity of the error and length of time between errors. Both reported that there was no threshold on when a staff had made too many errors. Neither staff could give an explanation as to why Staff PP had so many medication errors in 2014. 4. Review of a facility incident report dated 2/3/15 revealed staff noticed a bruise with a 2 to 3 inch spread on Resident #28's right hip. The facility determined the bruise was caused by the seatbelt buckle on the shower chair. The facility investigation indicated that Staff M would contact Staff N for consultation regarding a remedy. Interview with Staff N on 3/5/15 revealed she recommended placing a "pool noodle" (cushioned tube) over the belt buckle while Resident #28 showered. Staff N stated Staff M would be responsible for the purchase of the "pool noodle." Interview with staff M on 3/5/15 revealed she had not purchased the "pool noodle."	W 157		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure sufficient staff were available in order to meet the needs of one Resident (Resident #1) of 12 sampled residents. The failure of the facility to ensure staff were available	W 186		

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RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186	Continued From page 23 to meets the needs of Resident #1 resulted in Resident #1 not being able to work and or leave the dining room when he was finished eating. Findings include: Interview with Staff S on 3/3/15 at 9:30 AM acknowledged there were 14 residents residing on [redacted] House with significant basic care needs which included 7 residents on the [redacted] side of the house (Resident #29, #2, #36, #37, #15, #1 and #22) and 7 residents on the [redacted] side of the house (Resident #7, #41, #27, #40, #26, #39 and #38. Several residents (Resident #26, #27, #42, #29, and #22) required additional supervision with toileting and that required staff assistance. In addition, several residents (Resident #22, #1, #29, #7 and #27) had motion alarms in their bedrooms for protection of injury that required staff to investigate when the alarm sounded. Staff S reported 4 direct care staff work on the house which includes 2 direct care staff on the A side of home and 2 direct staff on the B side of home during the AM and afternoon shift. Overnight shift has 2 direct care staff on the house which includes 1 direct care staff working the A side of the house and one direct care staff working the B side of the residence. Resident #1 received PRO (Protective Supervision) for known PICA behavior (ingesting a nonnutritive item) and must remain in line of sight at all times. On 3/3/15, following a dinner meal 4:50 PM, Staff RR is observed bringing Resident #29 into the living room and assists him into a recliner and secures the seat belt and returns to the kitchen area to sweep the floor. Resident #1 is escorted into the kitchen where a chair is placed for Resident #1 to sit on while the ACM loads the dishwasher. Observation on 3/3/15 at 11:00 AM during the	W 186		

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W 186	Continued From page 24 lunch meal, 3/4/15 at 4:00 PM during the dinner meal and 3/9/15 at 11:00 AM during the lunch meal Resident #1 is observed eating his meal and when finished brings his dishes to the kitchen. Various staff escort Resident #1 back to the dining room table where Resident #1 remains seated until other residents are finished with their meal. Interview with Staff S on 3/10/15 at 11:00 AM acknowledged Resident #1 is limited in what he can do as facility staff need to be near him at all times due to Resident #1 ' s known PICA behavior (ingesting a nonnutritive item). Staff S acknowledged Resident #1 could do a lot more and has a boring life. Staff S acknowledged Resident #1 requires line of sight supervision at all times, and Resident #1 ' s daily routine is driven by staff responsibilities not Resident #1 ' s choice. Staff S acknowledged there is not enough direct care staff to meet the needs of Resident #1. Interview with Staff BB on 3/10/15 at 3:00pm acknowledged staff does the best they can with staff available. Staff BB acknowledged Resident #1 will sit with them and Resident #1 ' s activities are based on what staff needs. Interview with Staff CC on 3/9/15 at 9:30 AM acknowledged Resident #1 could work and is quite capable of doing more. By not having a one to one staff Resident #1 is not able to work. Staff acknowledged a request was made for additional staffing for Resident #1 that was denied. Record review of Psychological Assessment dated 2-17-15 revealed Resident #1 receives protective supervision defines as " line of sight and no more than 10 feet away from a staff member " . Resident #1 ' s quality of life was greatly enhanced by having all day meaningful employment that he enjoyed. As staff levels have	W 186		

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W 186	Continued From page 25 decreased, Resident work hours have been cut because his work is limited to times that 1:1 supervision is available.	W 186		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure staff provided a continuous, active treatment program for Residents to develop skills for greater independence, failed to encourage Residents to make choices and self-manage their daily routines, failed to ensure staff implemented programs which had been developed based on assessed needs, and failed to ensure there were enough staff assigned to meet the needs of all Residents. This failure prevented the residents from receiving necessary services and supports to promote greater autonomy and independence and resulted in the Condition of Participation of Active Treatment Services to be not met. Findings include: See W186, W196, W247, and W249	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self	W 196		

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W 196	Continued From page 26 determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure four of 12 Sampled Residents (Residents #4, #5, #10, and #11) received a continuous, consistently implemented program of supports, services, and training to meet their needs. Failure to ensure Residents were provided active treatment prevented them from acquiring skills to increase their independence. Findings include: Resident #11 1. On 3/3/15 from 9:23 AM to 9:55 AM, Resident #11 was observed seated in a wheelchair at a table in the dining room of the A side of [redacted] House. There was no activity occurring. At 9:33 AM a staff asked her if she wanted to do a puzzle and got a 9 piece non-interlocking wooden puzzle and placed it in front of Resident #11 and then walked away. She did not do the puzzle. Staff did not continue to engage with her. At 9:39 AM a different staff tried to get Resident #11 to do the puzzle. Again, she did not do the puzzle. The observation ended at 9:55 AM. Staff D was interviewed at the end of the observation and she revealed Resident #11 was new to the house. 2. On 3/3/15 from 3:02 PM to 3:28 PM, Resident #11 was observed sitting at a table in the A side dining room of [redacted] House. There were wooden puzzles and a wooden stacking ring toy on the table. At 3:09 PM a staff handed Resident #11 one of the stacking ring pieces. Resident #11 put the piece back on the table. At 3:11 PM, Resident #11 was talking to herself in a loud voice	W 196		

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W 196	Continued From page 27 saying " Get no shot today " and other phrases. At 3:18 PM a staff involved in New Employee Orientation sat with her and handed her pieces of the stacking ring toy. She put 8 pieces on when they were handed to her one at a time. At the end of the observation, an interview with Staff C revealed the purpose of the activity was to develop fine motor skills. 3. On 3/4/15 from 10:00 AM to 10:58 AM, Resident #11 was observed lying on a couch on the A side living room of [redacted] House. A staff asked her if she wanted a snack and assisted Resident #11 to a dining room table. Resident #11 had milk and cookies. At 10:10 AM she finished her snack and a staff asked her, " Want to do an activity? " . They offered her a board with geometrically shaped blocks but she pushed it away. The staff then gave her a children ' s picture book which she began looking at. At 10:20 AM Staff K had her transfer back into her wheelchair, at which point she yelled " Want a cookie " , and " I want a cookie " . So Staff K assisted her to have more cookies, apparently unaware that Resident #11 had just had cookies a few minutes earlier. At 10:45 AM she was back lying on the couch. At 10:56 AM a staff rubbed some lotion on her arms and hands and directed Resident #11 to rub it in completely. At 10:58 AM she was back in her wheelchair to get ready for lunch. 4. On 3/6/15 from 9:25 AM to 10:03 AM, Resident #11 was observed in the dining room of her home at [redacted] House. The initial observation revealed she was sitting in her wheelchair at a table. There was no activity at the table. At 9:28 AM a staff put a wooden block toy in front of her, but she did not do anything with it. At the end of the observation Staff G was interviewed and said the purpose of the activity	W 196		

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W 196	Continued From page 28 was socializing, learning shapes and colors and for interaction. Review on 3/9/15 at 10:00 AM of Resident #11 ' s record revealed she had moved to [redacted] House on [redacted]15 from [redacted] House in a separate ICF/IID facility at Rainier School. On 3/10/15, Staff II was interviewed with Resident #11 ' s record available. He revealed Resident #11 was fairly new to [redacted] House having moved there from another house at Rainier School in a different ICF/IID facility. He stated her 30 day Individual Habilitation Plan meeting had been held 2/26/15 and that there were some changes but for the most part her plan was quite similar to the 12/2/14 IHP from [redacted] House. He stated staff were still getting to know her. Resident #4 1. On 3/3/15 from 10:15 AM to 10:38 AM, Resident #4 was observed seated at a table in the living room area of [redacted] House. Resident #4 was seated in a wheelchair that was tilted back. Staff E played bingo for the Residents. Staff E spun the cage with the bingo numbers, told the Residents if they had a match, and then placed a marker on their card as needed. At approximately 10:30 AM, Staff F got a giant " Connect Four " game and placed a piece into Resident #4 ' s hand, with difficulty, and then attempted to have Resident #4 put the piece into the game board. She did not let go of the piece readily. Only 1 piece was attempted. At the end of the observation, when interviewed about the purpose of the activity, Staff F stated it was to help loosen her up. 2. On 3/3/15 from 5:18 PM to 5:40 PM, Resident #4 was seated in her wheelchair in the living room of her home. She was one of three Residents sitting in wheelchairs near the table where Staff G	W 196		

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W 196	Continued From page 29 was playing a game called " Sharp Shooters " with them. The game involved throwing a number of dice onto a board and then making a determination as to where to place the dice on the game card if matches occurred. Initially Staff G was doing all of the game activities herself. Later, as the surveyor approached and asked about the game, Staff G began " putting " the dice near the Residents hands, or attempting to have the Residents hold the dice before throwing them onto the board. At the end of the observation when interviewed, Staff G said the purpose of the activity was to get them involved. 3. On 3/4/15 from 9:20 AM to 9:51 AM, Resident #4 was observed in her bedroom. She was seated in her wheelchair in the middle of her bedroom and there was music playing and a fan blowing on her. At the end of the observation, Staff J was interviewed and revealed having the fan blowing on her helped relax her. 4. On 3/5/15 from 9:00 AM to 10:10 AM, Resident #4 was observed in her home and then later in an activity room. At the start of the observation, Resident #4 was in a peer ' s bedroom in front of the TV. Another Resident was in the room as well. At 9:12 AM a staff brought her out into the living room and put her tennis shoes on. The TV was on but Resident #4 was far away from it and other Residents were blocking her view. At 9:18 AM a staff took her into the bathroom and she was in the bathroom for a total of 25 minutes. After coming out of the bathroom, she was taken to a large room in the same building where there was an activity to make a clover for St. Patrick ' s Day out of colored paper. Resident #4 was not able to cut the paper or fasten it together. The activity was performed by the staff. At the end of the observation, Staff L was interviewed and revealed	W 196		

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W 196	Continued From page 30 Residents are chosen to come to the arts and crafts room based on who they think would benefit. Staff L said was directed to take Resident #4 to the activity that day. 5. On 3/6/15 from 10:08 AM to 10:29 AM Resident #4 was observed in the activity room where a painting activity occurred. Resident #4 was observed with a baseball-style cap which was low down on her forehead partially obstructing her ability to see outward. Staff O painted the picture for Resident #4. Staff O was interviewed at the end of the observation and revealed the purpose of the activity was for engaging and socializing. Review on 3/6/15 of Resident #4 ' s record revealed her IHP dated 2/6/15 stated her long range training goal as " [Resident #4 ' s name] will maintain her overall range of motion through completion of training objectives in the areas of dressing, facewashing, dining, toothbrushing and choicemaking by 2017. " Interview on 3/9/15 at 3:25 PM with the QIDP, with Resident #4 ' s record available, verified a main focus of Resident #4 ' s training was to maintain her range of motion. She verified that many of the activities observed by the Surveyor did not have staff focusing on the Resident #4 ' s range of motion. Resident #10 1. Observation was initiated at 7:00 AM on 3/3/15 in [redacted] House. At 7:32 AM, Resident #10 was seated at the dining table eating breakfast. At 8:10 AM, Resident #10 was observed sitting in her rocking chair holding a piece of fabric with textured items attached. House staff referred to this item as a texture apron. At 8:15 AM, Staff DD asked Resident #10 how she was doing and at 8:24 AM, Staff EE asked Resident #10 how she was doing. At 8:37 AM, Staff EE asked	W 196		

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W 196	Continued From page 31 Resident #10 if she wanted to go join the activities in the other room then without waiting for a response from Resident #10, he walked over to two other non-sampled residents. Resident #10 remained seated in her rocking chair. Between 8:10 AM and 9:00 AM when the observation ended, there were no activities in which Resident #10 was involved in an active treatment program intended to teach skills or increase independence. 2. Observation was initiated at 3:07 PM on 3/3/15 in [redacted] House. At that time, Resident #10 was sitting in her rocking chair with no activities. Four other non-sampled residents were also sitting in the same living room area without any activities. At 3:10 PM, Staff FF began asking if residents in the living room area if they wanted to sit outside in the backyard. Resident #10 went outside and came back inside at 3:11 PM. At that time, Staff FF assisted Resident #10 with putting her coat on. Resident #10 walked outside for one more minute then came back inside the house and walked around the house until 3:22 PM when she sat down at a table which had soft blocks and magazines on it. There were no staff or other residents at the table and she did not engage with any items on the table. At 3:25 PM, Staff FF asked Resident #10 if she wanted to come to the other side of the house. At that time, Resident #10 was observed getting up from the table and walking around the house until 3:37 PM when she sat down in her rocking chair. At 3:43 PM, Staff FF cued Resident #10 to come to the table to have a drink alongside a non-sampled resident. Resident #10 walked to the table and at 3:45 PM Staff FF assisted Resident #10 with taking her coat off, which she had been wearing in the house since 3:11 PM. At 3:48 PM Resident #10 left the table and returned to her rocking chair	W 196		

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W 196	Continued From page 32 where she remained at 3:54 PM when observation ended. The room temperature in the house was warm and no other staff or residents were observed wearing their coats indoors. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence during this period of observation. 3. Observation was initiated at 10:25 AM on 3/4/15 in [redacted] House. Resident #10 was observed at that time sitting at the dining area table. Resident #10 was looking at her fingers and twiddling her thumbs, not engaging in the blocks, bead tracks, or magazines sitting on the table. At 10:28 AM Resident #10 walked towards the back of the house with an unknown nurse and returned to her rocking chair at 10:31 AM. Resident #10 remained in her rocking chair without any activities until 10:50 AM when Staff DD asked her if she wanted to wash her hands for lunch. Resident #10 was observed eating lunch for the duration of the observation which ended at 11:38 AM. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence. 4. Observation was initiated at 3:55 PM on 3/4/15 in [redacted] House. Resident #10 was sitting in her rocking chair in the living room area holding her texture apron. At 4:15 PM, Staff GG cued Resident #10 to come to the dining room table for dinner. At 4:52 PM Resident #10 returned to her rocking chair after dinner and held her texture apron. No activities were offered. The observation ended at 4:54 PM. 5. Observation was initiated at 10:05 AM on 3/5/15 in [redacted] House. Resident #10 was sitting in the living room area in her rocking chair, holding her texture apron. Two other non-sample	W 196		

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W 196	Continued From page 33 residents were also sitting in the same room with no activities. At 10:07 AM, Staff HH came in from the back yard and asked one of the non-sample residents if she would like to draw outside with chalk. No activity was offered to Resident #10. At 10:22 AM, Staff HH came in from outside and handed Resident #10 her texture apron which she had let go of. Resident #10 remained in her rocking chair without any activity until 10:56 AM at which time Resident #10 went to the bathroom to wash her hands for lunch with staff assistance. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence during this 52 minute observation. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10 ' s Individual Habilitation Plan (IHP), IHP CODE & Prob # 4015 T07 A stated given a gestural and verbal cue, Resident #10 will remain at an activity with her peers for 3 minutes. The objective was to teach Resident #10 to be able to regulate her anxiety during group activities. During the observations from 3/3/15 through 3/5/15, Resident #10 was asked one time on 3/3/15 by Staff EE if she wanted to join other residents in the other room for activities. At no other time were activities offered or suggested to Resident #10. The IHP stated praise is a great reinforcer for her, and she likes knowing she has done a good job. The IHP stated Resident #10 does seem to appreciate an occasional light pat/rub on her back or head from known staff. There were no observations of staff praising Resident #10 or offering physical touch. Resident #10 ' s IHP also stated with objective #2071 she will express her wants, needs, and negations using natural gestures as a way to teach appropriate ways of expressing her agitation and anxiety. It is noted	W 196		

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W 196	Continued From page 34 in the IHP that Resident #10 will display increased anxiety by leaving an area. On 3/3/15 when Resident #10 walked around the house for a total of 22 minutes, there was no staff intervention or involvement in assisting Resident #10 to express her needs and desires. During an interview with Staff EE at 8:37 AM on 3/3/15, when asked about Resident #10 ' s texture apron, he stated Resident #10 likes to manipulate things and she has had that behavior for 17 years. Staff II, the Qualified Intellectual Disability Professional (QIDP), was interviewed on 3/10/15 at 10:25 am. He stated staff may use Resident #10 ' s anxiety as a reason not to interact with her, especially if there is an activity coming up within 30 minutes. Resident #5 1. Observation on 3/2/15 at [redacted] house between 10:55 AM and 11:33 AM revealed Resident #5 was sitting in the living area of the home buckled into a recliner. Resident #5 continuously handled two strings that were attached to a metal hook that was fastened to a piece of wood (knot board). A staff passed through the area and stated "are you threading your board?" At 11:03, Staff R was observed bouncing a ball to other residents who were seated in the same area. Staff R asked Resident #5 if she wanted to play ball. Resident #5 did not respond. (Resident #5 was observed to be blind) Interview with Staff R about the purpose of the ball activity revealed it was designed to "engage residents" and work on "motor skills". 2. Observation on 3/2/15 at [redacted] House between 3:45PM and 4:00pm revealed Resident #5 sat in a recliner with a seat belt around her waist. No staff interacted with her. 3. Observation on 3/3/15 at [redacted] House between 9:25 AM and 10:30 AM revealed	W 196		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	Continued From page 35 Resident #5 was buckled into a recliner. She was handling the strings on the knot board. At 9:45 AM, Staff H tied the two strings into multiple little knots. Resident #5 manipulated the knots until the knots were undone. At 10:07 AM staff state to Resident #5" I see you have undone your knots." There was no other type of staff interaction. Interview with a staff working in the area about the purpose of the activity revealed Resident #5 works on her fine motor skills. 4. Observation on 3/3/15 at [redacted] House between 3:20 PM and 4:20 PM revealed Resident #5 was seated in a wheelchair handling the strings on the knot board. At 3:25 PM Staff T noticed something on Resident #5's face and washed her face. At 3:27 PM Staff T handed Resident #5 a piece of cloth with strings attached to it. Resident #23 did not do anything with the cloth. At 3:44 PM Staff T tied knots in the strings attached to the knot board and handed the board to Resident #23. There was no other type of staff interaction. 5. Observation on 3/3/15 at [redacted] House between 5:10 PM and 6:20 PM revealed Resident #5 was buckled into her wheelchair handling the strings on the knot board. At 5:15 PM, Staff T took Resident #5 into her room to change her shirt. This took approximately 5 minutes. At 6:05 PM, Staff T tied the strings on the board for Resident #5 to undo and then he assisted her to put a coat on. Resident #23 sat in her wheelchair with her coat on, handling the strings on the knot board until she left with staff at 6:20 PM. Staff T was asked where Resident #5 was going. Staff T stated to "watch a video on Zumba at PAT headquarters." 6. Observation on 3/4/15 at [redacted] House between 9:55 AM and 11:25 AM revealed Resident #5 was buckled into a wheelchair at the	W 196		

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W 196	Continued From page 36 dining room table handling the strings on the knot board. Staff P was in the dining area of the home. At 10:10 AM, Staff P placed her hands over Resident #5's hands and assisted Resident #5 to untie the knots. (Resident #5 was observed to be able to independently untie the knots on previous days) Interview with Staff P about the purpose of the activity, Staff P stated "texture" and that she can "independently thread the board and staff do not need to help her with that." 7. Observation 3/5/15 at 7:45 AM revealed staff brought Resident #5 into the living area of the home. Staff M handed Resident #5 a cloth with strings on it and stated "here is your macramé." At 7:55 a staff asked Resident #5 where her board was. The same staff left the area and returned with the knot board, knotted the strings together and placed the board in front of Resident #5. At 8:15 AM staff pushed Resident #5 to dining room table. Review of the IHP dated 3/18/14 for Resident #5 revealed the interdisciplinary team met and determined the focus of Resident #5's active treatment plan should include decreasing self-injurious behavior and increasing her current levels of independence in personal care and daily living routines. In addition Resident #5 has a" knot board that she uses from time to time." None of the state surveyors observations of Resident #5 appeared to be designed to increase current levels of independence in personal care and daily routine. Interview with Staff WW on 3/10/15 regarding the active treatment program for Resident #5 revealed the program included a tooth brushing program, sensory program, wet washcloth program and a calming preferred activity. Staff WW stated Resident #5 likes the "knot board."	W 196		

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W 247	Continued From page 37	W 247		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to allow two of 12 Sampled Residents (Resident #1 and #10) to manage their own food preferences and self-manage their daily routines. These failures prevented residents from exercising freedom of choice and self-regulation. Findings include: Resident #10 1. Observation was initiated at 10:50 AM on 3/2/15 in [redacted] House. At 11:00 AM, Staff UU offered Resident #10 a toasted cheese sandwich, beef barley stew, or a " ground sandwich. " The staff member dished up beef barley stew, potato salad, and macaroni salad without Resident #10 responding or assisting, then served her a cut up cheese sandwich once Resident #10 sat at the table. At 11:15 AM Staff UU brought cake in bowls to Resident #10 ' s table. At the table, with Resident #10 present, Staff UU asked Staff JJ if Resident #10 wanted whipped cream on her cake. Staff JJ said, " Oh probably. " Staff UU proceeded to put whipped cream on Resident #10 ' s cake without asking her if she wanted it. Resident #10 was observed during the meal time to eat independently with a spoon, yet at no time did Resident #10 use a spoon to self-serve her own meal. a. During observation at 7:38 AM on 3/3/15, Staff UU served breakfast to Resident #10 without giving her a choice of a breakfast item or	W 247		

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W 247	Continued From page 38 participating in self-management in serving her own meal. At 8:30 AM, Resident #10 was observed receiving her medications by Staff SS. Staff SS prepared Resident #10 ' s medications by mixing them with food then spoon fed them to her. Resident #10 was not given the opportunity to hold the spoon to administer her own medications. At 11:10 AM during lunch, Staff UU held Resident #10 ' s plate and dished up food while Resident #10 stood and watched. Resident #10 did not have a choice of food or have the opportunity to self-serve her meal. At 11:33 AM, Staff UU prepared cake muffins in individual serving bowls for the residents at the dining table. The staff member squirted whipped cream out of the can onto Resident #10 ' s cake without giving her the option of choosing whether or not she wanted any. b. At 11:05 AM on 3/4/15, Staff UU brought Resident #10 ' s mat, plate, and spoon to the table where Resident #10 was sitting down. The staff then carried the plate to the food service table while the named resident followed behind. Staff UU told Resident #10 what the food choices were then dished up the food on her plate. At 4:15 PM, Staff GG took the named resident ' s plate to the food service table by himself and dished up food on her plate before bringing it back to her. Resident #10 was not given an opportunity to choose what she wanted to eat or self-serve her own food during breakfast or lunch on this day. At 4:05 PM, Resident #10 did not participate in self-management of her medications. The nurse administering the medications mixed the medications with food then brought the medications to Resident #10 and spoon fed them to her. There was no opportunity for Resident #10 to self-administer her own medications.	W 247		

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W 247	Continued From page 39 c. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10 ' s Individual Habilitation Plan (IHP), IHP CODE & Prob # 1001 T 01 C, stated given gestures and a verbal cue, [Resident #10] will use a utensil to feed herself, with an average score of 4.0 or greater for 6 consecutive months. Resident #10 ' s was observed using a spoon to feed herself during meals. d. A joint interview on 3/10/15 at 10:25 am with Staff II and Staff KK revealed neither have witnessed Resident #10 ever participate in self-administration of her medication. When asked why Resident #10 does not take part in this activity, the QIDP stated Resident #10 flails her arms around which would possibly prevent her from getting her medications. The behavior of flailing arms around when receiving medications was not observed by the surveyor. Under letter " c " where record review is noted: Resident 10 ' s Comprehensive Functional Assessment (CFA) dated 11/20/14 stated [Resident 10] made choices from what feels good for the moment or what will satisfy a basic need. For her to be able to make choices, the options had to be presented to her in concrete form; things she can see; feel, touch, or activities she is familiar with. Resident 1 ' s CFA also stated she is able to follow simple one-step requests that are part of her daily routine and she is able to feed herself with a spoon. 2. Observation on 3/3/15 at 11:00 AM during lunch meal, 3/4/15 at 4:00 PM during dinner meal and 3/9/15 at 11:00 AM during lunch, Resident #1 is observed eating his meal and when finished brings Resident #1 brings his dishes to the kitchen. Various staff escort Resident #1 back to the dining room table where Resident #1 remains	W 247		

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W 247	Continued From page 40 seated until other residents are finished with their meal. Interview with Staff S on 3/10/15 acknowledged Resident #1 is limited in what he can do as facility staff need to be near him at all times due to Resident #1 ' s known PICA behavior (ingesting a nonnutritive item). Staff S acknowledged Resident #1 could do a lot more and has a boring life. Staff S acknowledged Resident #1 requires direct care staff to be near at all times and Resident #1 ' s daily routine is driven by staff responsibilities not Resident #1 ' s choice. Interview with Staff BB on 3/10/15 at 3:00pm acknowledged that staff do the best they can with available staff. Staff acknowledged Resident #1 will sit with them and Resident #1 ' s activities are based on what staff needs.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure individual program plans were consistently implemented for two of 12 Sampled Residents (Residents #6 and #10). This failure prevented the residents from having an opportunity to learn skill development and work toward accomplishing their objectives.	W 249		

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W 249	Continued From page 41 Findings include: 1. At 7:15 AM on 3/3/15, Resident #10 was seated at the dining room table. Staff UU picked up Resident #10 's cup from the table, walked away from the table, poured juice into the cup, then brought the filled cup back to Resident #10. At 3:43 PM, Staff FF cued Resident #10 to sit down next to a non-sampled resident to get a drink. Staff FF got a cup from the shelf and brought it to Resident #10 at the table. At no time on this day was Resident #10 observed retrieving her cup from the place setting in the dining area where it is stored between meals. a. Observation at 11:05 on 3/4/15 revealed Resident #10 sat down for lunch and Staff UU retrieved Resident #10 's cup from the place setting in the dining area and brought it to her at the table. Resident #10 was not provided the opportunity to pick up her cup. At 3:55 PM, when the surveyor arrived at Resident #10 's home, her place setting, including her cup, was already set out on the dining table for dinner. b. Between 4:30 PM and 4:37 PM on 3/4/15, Resident #10 ate most of her dinner of mixed vegetables, ham, and macaroni and cheese with her fingers. At 4:35, staff cued her spoon. Resident #10 ate with her spoon for 10 seconds then resumed using her fingers. There were no other cues from staff. c. During observation at 8:30 AM on 3/3/15, Resident #10 received her medications from Staff SS when the staff pushed the cart towards the chair where Resident #10 was sitting. At 3:50 PM, Resident #10 received her medications from Staff PP. Staff PP prepared Resident #10 ' s medications at the medication cart then brought the cart to Resident #10 in her rocking chair. During both medication passes, each staff member spoon fed the medications to Resident	W 249		

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W 249	Continued From page 42 #10. Neither time, Resident #10 was not called to come to the medication cart or given an opportunity to use a utensil to feed the medications to herself. d. Observation at 4:05 PM on 3/9/15 revealed Resident #10 received her medications from LPN2 TT after he pushed the cart to where Resident #10 was sitting. He then spoon fed the medications to her. There was no opportunity or cue for Resident #10 to come to the medication cart or participate by using a utensil to feed herself. e. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10 ' s Individual Habilitation Plan (IHP),dated 11/20/14 IHP CODE & Prob # 1001 T01 C, stated given gestures and a verbal cue, [Resident #10] will use a utensil to feed herself, with an average score of 4.0 or greater for 6 consecutive months. Her IHP CODE & Prob # 1005 T01 B/C stated given verbal and visual cues, [Resident #10] will indicate her desire for a drink by picking up her glass from her place setting in the dining room, with an average score of 6.0 or greater for 6 consecutive months. Record review of Resident #10 ' s Service Plan Revision, approved on 12/29/14 found Prob #8052 which stated Resident #10 would come to the medication cart when her name was called. f. A joint interview on 3/10/15 at 10:25 am with Staff II and Staff KK revealed neither have witnessed Resident #10 ever participate in using a utensil in self-administration of her medication. Staff II reported Resident #10 flails her arms around which would possibly prevent her from getting her medications. This behavior was not observed by the surveyor. 2. Review of the Individual Habilitation Plan dated 7/14/14 revealed Resident #6 ' s	W 249		

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W 249	Continued From page 43 wheelchair should be used only when Resident #6 was unsteady or having difficulty walking. a. Observation at Buckley House on 3/2/15 at 10:55 AM revealed Resident #6 was sitting in an easy chair in the living area of the home. At 11:11, Staff M assisted Resident #6 from the recliner into a wheelchair. Staff M then pushed Resident #6 into the dining room. Staff M assisted Resident #6 from the wheelchair to the dining room chair. b. Observation at Buckley House on 3/3/15 at 3:20 PM revealed Resident #6 was sitting in a recliner chair in the living area of the home. At 4:15 PM, Staff M assisted Resident #6 from the recliner into a wheelchair. Resident #6 started self-propelling herself towards the dining area of the home. Staff stepped in and pushed her chair to the dining room table. Resident #6 was then assisted from the wheelchair to the dining room chair. c. The state surveyor asked Staff M why Resident #6 was never observed walking in her home. Staff M stated Resident #6 has an awkward gait and she and Staff P cannot assist her to walk. Staff M added that some of the male staff (who were larger in stature) could assist Resident #6 to walk around her home.	W 249		
W 301	483.450(d)(4) PHYSICAL RESTRAINTS A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints. This STANDARD is not met as evidenced by: W301 - Based on observation, record review and interview the facility failed to ensure Residents	W 301		

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W 301	Continued From page 44 were checked while being restrained either on a toilet, in dining room chair or in a recliner. This failure resulted in Residents being placed in restraints and left for long periods of time without staff ensuring residents were safe, comfortable, and if restraint needed to be released. Findings include: Dining Room Chairs Observation on 3/5/15 at Buckley house between 7: 10 AM and 7:48 AM revealed Resident #6 was seated in a dining room chair with a seat belt buckled around the middle of her chest. There were no staff in the room. Resident #6 sat upright in the chair, picking at her shirt, wiggling her feet and looking around. Resident #6 never tried to remove the restraint. At 7:48 AM a staff entered the dining room and pushed her chair up to dining room table. At 8:12 AM a staff dished Resident #6's breakfast into a bowl and Resident #6 started eating. At no time did staff check to ensure the restraint was fitted properly or if Resident #6 was comfortable. Record review on 3/9/15 of Resident #6's IHP dated 7/14/14 revealed the dining room chair restraint was to be used only when Resident #6 was eating. Interview with Staff Q on 3/11/15 about the use of the restraints in dining room chairs revealed the facility uses the seat belts that are attached to the dining room chairs as "positioning devices" and should only be used when eating. Toilet Seat Restraints Observation between 3/2/15 and 3/11/15 at [redacted] house revealed Resident #30 capable of walking, sitting and standing independently. Observation on 3/5/15 at [redacted] house revealed an Adult Training Program staff took Resident #30 into the bathroom at 7:50 AM. The ATP staff came out of the bathroom. The ATP staff started	W 301		

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W 301	Continued From page 45 assisting resident s with breakfast. The ATP did not check on Resident #30. At 8:17 AM, the surveyor asked the ATP staff to produce the toilet support log for Resident #30. The ATP staff went to the bathroom and gave the restraint log to the surveyor. The ATP staff had not entered the time she put Resident #30 on the toilet. Resident #30 sat, restrained on a toilet for 27 minutes until the surveyor intervened. Review of the toilet support log for 3/5/15 revealed staff had not documented when Resident #30 was put on the toilet, when, or if she had been checked. Review of the facility's policy title SOP 3.13 revealed residents placed in a "toilet support" device will be monitored at a minimum of every ten minutes. Interview with Staff M on 3/4 /15 revealed Resident #30 needed to be kept on the toilet until staff could assist her to clean herself properly.. Recliner Restraints 1. Observation of Devenish living rooms (A and B side of the house) on 3/2/15 at 10:50 AM revealed a number of recliners with seatbelts. On 3/3/15 at 4:50 PM following a dinner meal, Staff RR was observed bringing Resident #29 into the living room. Staff RR assisted Resident #29 into recliner and restrained him using the seatbelt. Staff RR then returned to the dining room area to sweep the floor. Resident # 29 was observed squirming in the recliner in an attempt to get up. Observation on 3/9/15 at 10:45 AM and 3/5/215 at 8:00 AM Resident #26 and Resident #27 are observed restrained in a recliner in the living room using a seatbelt. Interview with Staff Y at 8:00 AM on 3/5/15 acknowledged Resident #26 is restrained in the recliner for safety reasons and to prevent her from walking around so she doesn ' t roam. Staff	W 301		

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W 301	Continued From page 46 Y acknowledged Resident #26 used to hate the use of the seatbelt but now is getting used to them. When asked why Resident #27 was restrained in the recliner with a seatbelt, Staff Y acknowledged she didn ' t know exactly why then reported use of seatbelts were always for safety. Interview with Staff Z on 3/4/15 at 10:45 AM acknowledged the use of seatbelts were for safety and for resident protection. Staff Z revealed Resident #26 and Resident #27 were not stable walking and would hurt themselves. Record review of Individual Habilitation Plan (IHP) for Resident #26 dated 10/16/14; Resident #27 dated 8/5/14 and Resident #29 dated 9/18/14 revealed use of adaptive/mechanical support were considered restrictive as the resident cannot remove them and with such equipment would be at risk of injury.. Interview with Staff S on 3/10/15 at 2:50 PM acknowledged staff did not track how long residents were kept seatbelted into recliners.	W 301		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 12 Sample Residents (Resident #4) received nursing care as directed by the Physician when a nurse administered Resident #4 seven consecutive vaginal douches to clear fecal material. This failure resulted in Resident #4 receiving treatment not ordered by the Physician. Findings include:	W 339		

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W 339	Continued From page 47 Review on 3/6/15 of Resident #4 ' s record revealed an entry in her Health Progress Notes, dated 1/23/15, which indicated Resident #4 had received 7 vaginal douches in an attempt to clear fecal material from her vagina. A Physician ' s Order dated 10/10/14 revealed she was to have a vaginal douche. Review on 3/6/15 of Resident #4 ' s record revealed she was diagnosed with [redacted] disease, was confined to a wheelchair, and was non-verbal. Interview on 3/10/15 with Staff AA revealed Resident #4 wears an Attends (protective undergarment). She often makes back and forth motions with her pelvic area while in her wheelchair and that this leads to fecal matter getting into her vaginal area. She verified the douche was to remove the fecal matter. Staff AA also verified Staff XX had not followed the Physician ' s orders when 7 douches were completed.	W 339		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

January 13, 2014
CERTIFIED MAIL (7008 1300 0000 7188 4436)

Neil Crowley, Superintendent
Rainier School PAT A
PO Box 600
Buckley, Washington 98321

RE: Recertification Survey
12/06/2013 through 12/11/2013

Dear Mr. Crowley:

From 12/06/2013 through 12/11/2013 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review); and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G050	A. BUILDING _____ B. WING _____	12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

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W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey conducted at Rainier School - PAT A from 12/06/13 through 12/11/13. The Fundamental Recertification Survey was conducted by observation, documents review and interview. A random sample of 12 Residents were selected from a census of 122 Residents. The survey was conducted by: Christina Borchardt, RN, BSN Janette Buchanan, RN, BSN Terry Patton, RN, BSN Penny Rarick, BA The survey team is from: State of Washington Department of Social and Health Services Residential Care Services Administration ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to monitor staff and ensure proper program implementations of a toilet monitoring program for 1 of 12 sampled	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 1/23/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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W 104	Continued From page 1 residents (Resident #10). This failure placed resident ' s health and safety at risk. Record review of Resident #10 ' s Individual Habilitation Plan (IHP) Health and Safety Considerations revealed the following: Resident #10 toilets with staff assistance to go to the bathroom, undress, etc. Staff should continue to provide opportunities for her to toilet on approximately a two-hour schedule. Staff to follow Standard Operating Procedure #3.13 (Adaptive Equipment and Mechanical Supports) and document every 5 minutes on her monitoring logs. Resident #10 should not be left on the toilet for more than a few minutes at a time as she tends to get very uncomfortable sitting on the commode. Record review of Service Care Plan #1030, dated 01/31/13 revealed service to be provided when Resident #10 is seated on the toilet: staff will apply a wide chest support strap and safety belt, to maintain appropriate sitting posture and protect her from potential injury, should she attempt to stand or fall from the toilet. Observation of Resident #10 on 12/06/13, 12/07/13 and 12/08/13 revealed two incidents where resident had not been observed being offered toileting assistance, however staff documented several hours later that toileting had occurred. Observation also revealed staff failed to complete the Toileting Monitoring Log until several hours after the toileting assistance, often at the end of a shift. Resident #10 was observed on 12/06/13 to be sitting in her wheelchair next to the television area at 5:00PM. Staff was not observed assisting her	W 104	**W104 – Governing Body** For client #10, Buckley house staff will be trained on SCP#1030, SCP#1000,H&S#7 (IHP dated 1/14/14) and SOP 3.13 regarding toileting schedule as well as timely and appropriate documentation of data. Completion 1/31/14 All PAT A direct care staff will be trained on SOP 3.13 regarding timely and appropriate documentation of data. Completion 2/14/14 For PAT A Houses, AC Shift Charges will monitor on a daily basis per shift to ensure timely and appropriate documentation of data. AC Managers will complete a minimum of four random observations per month to ensure timely and appropriate documentation of data. Completion 2/14/14 and ongoing **Person Responsible** ACM **Monitor** PAT A DDA1 & DDA2	

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W 104	Continued From page 2 with toileting during the hours of 5:00PM to 7:30PM. Record review of Resident #10 's Toilet Support Monitoring Log On 12/06/13 at 7:00 PM revealed one entry at 9:30AM. There were no other entries in the log for 12/06/13. The toileting log had not been completed between the hours of 9:30AM and 7:00PM. Document Review of Resident #10 's Toilet Support Monitoring Log on the following day (12/07/13) at 7:45AM revealed the toileting log had been filed in after the state surveyor review at 7:00PM on 12/06/13 and it now contained entries to show toileting had occurred at 14:30, 16:30, 18:30 and 20:30. The toileting log included toileting times when Resident 10 was under observation and had not been toileted. Resident #10 was observed on 12/07/13 to be sitting on the chair next to the television from 7:30 AM to 9:30AM. Staff was not observed assisting her with toileting during the hours of 7:30AM to 9:30AM. Review of Resident #10 ' s Toileting Support Monitoring log on 12/07/13 at 7:45AM and 1:30PM revealed the toileting log had not been completed between the hours of 7:45AM and 1:30PM on 12/07/13. Record Review of the Toilet Support Monitoring Log on the following day (12/08/13) at 6:00AM revealed entries had been made after the state surveyor review at 1:30PM on 12/07/13 and the log now contained entries to show toileting had occurred at 8:45AM, 10:45AM and 12:45PM. There were no entries to show toileting had been performed after 12:45PM on 12/07/13. The toileting log included toileting times when	W 104		

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W 104	Continued From page 3 Resident 10 was under observation and had not been toileted. Interview of ACM (Staff L) revealed staff are expected to complete the Toilet Support Monitoring Log during the toileting process or immediately after the toileting is complete. This is to ensure safety due to the resident requiring a chest support strap and safety belt. Staff L revealed it was highly unlikely that staff were able to assist with toileting exactly two hours apart as the toileting log indicated on 12/06/13 and 12/07/13. Staff L acknowledged it was difficult to determine if staff had failed to assist the resident with toileting, failed to monitor while the resident was toileting or failed to complete the log.	W 104		
W 116	483.410(c)(6) CLIENT RECORDS The facility must provide each identified residential living unit with appropriate aspects of each client's record. This STANDARD is not met as evidenced by: Based on records review and interviews, facility failed to maintain records for 1 of 12 sampled residents (Resident #4) at his living unit. Failure to maintain a record where all staff have access prevents staff from knowing how to interact with the resident to maximize the resident 's health and to avoid activities which may be harmful to the resident ' s health and well-being. Findings include: Interviews and record reviews were conducted 12/06/13 through 12/11/13 unless otherwise specified.	W 116		

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W 116	Continued From page 4 Review of Resident #4 ' s records on 12/09/13 revealed he had [1, 3] surgery on [1, 3] 13. Records of follow-up visits to the surgeon ' s office on 02/27/13 and 03/27/13 revealed Resident #4 was to start Physical Therapy. Progress Notes written by Staff Y, an Attendant Counselor on the afternoon shift, dated 03/29/13, 04/10/13, and 08/08/13 revealed that by 08/08/13 Resident #4 could walk around the house unassisted and could walk longer distances holding on to someone ' s hand. Interview with Staff I revealed that Staff Y should not have been walking Resident #4 because Resident #4 did not wear a gait belt. Records review at Resident #4 ' s residence revealed no records during the time Staff Y was helping Resident #4 to walk without a gait belt, that staff should not have been walking Resident #4 without a gait belt. Staff I stated the Physical Therapist stopped trying to help Resident #4 to walk in March of 2013 because Resident #4 would not wear a gait belt. The most recent Physical Therapy report revealed in Resident #4 ' s records at his residence was dated 7/20/10. An interview on 12/10/13 with Staff J (Physical Therapist) at her office revealed she discharged Resident #4 from Physical Therapy on 03/18/13 due to his refusal to wear a gait belt. Staff J provided a Physical Therapy Report dated 02/21/13, a note dated 03/18/13 and a hand written note dated 5/20/13. Staff J stated that none of these 3 notes are in Resident #4 ' s records at Haddon House. Staff J was asked how staff (including Staff Y) working at Resident	W 116	**W116 Client Records** For client #4, all Physical Therapy reports from 7/20/10 thru 12/17/13 will be placed in client #4's file. Completion 1/31/14 For all PAT A clients receiving direct treatment by Physical Therapy, evaluations/assessments will be placed in the client's file within 30 days of service. Completion 2/14/14 and Ongoing PAT A HPA's will complete a file check for those clients receiving direct physical therapy treatment on a quarterly basis. Completion 2/14/14 and Ongoing **Person responsible:** RPT/PTA **Monitor:** HPA Clinical Director & PAT A DDA1 & DDA2	

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W 116	Continued From page 5 #4 ' s residence were supposed to know they were not to ambulate Resident #4 without a gait belt. Staff J stated if someone wanted to see her notes regarding Resident #4, they could ask her for them or they could go to the facility records office to obtain them.	W 116		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to provide opportunities for meal choices for 2 of 12 sampled residents (Resident #9 and #11) and 4 of 35 expanded sample residents (Resident #17, #18, #22 & #23). This failure did not afford the resident the decision to choose what they wanted to eat. Findings include: Observation and interviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Observation of dinner on 12/06/13 and breakfast on 12/08/13 revealed Resident #11 was provided a special pureed diet prepared by the main facility kitchen. Staff did not offer Resident #11 a choice or alternative meal for the specialized diet. Observation of lunch 12/08/13 and breakfast 12/10/13 Resident #17 & #18 were provided a special pureed diet and Resident #18 was provided a Diabetic ground diet that were prepared by the main facility kitchen. Staff did not offer a choice or alternative meal for the specialized diets. However, Resident #17 was offered a dessert choice.	W 247	**W247 Individual Program Plan** For clients #9, 18, and 23, food choices will be offered at the start of each meal. For clients # 11, 17 and 22, it is medically contraindicated to provide them a food choice variety. Completion 1/31/14 All PAT A direct care staff will receive inservice training regarding providing appropriate food choices to each client at the start of every meal. Completion 2/14/14 PAT A AC Managers will complete a minimum of 10 meal time observations per month to ensure appropriate meal choices are offered at the beginning of each meal. Completion 2/14/14 and Ongoing **Person Responsible:** ACM's & HPA's **Monitor:** DDA1 & DDA2	

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W 247	Continued From page 6 Observation of lunch on 12/08/13 Resident #9 and #23 were not offered an alternative to their meals (2200 chopped and 2200 ground textures). Resident #9 and #23 were offered peanut butter and jelly sandwiches only after they refused to eat the food that had been served. Residents that received a regular house diet (regular, chopped or ground textures) were given their food and only offered a choice if they did not eat the food served. Interview with Staff D revealed staff were aware they were to offer choices to residents at all times for meals, however she was unsure why they did not offer choices. Staff D revealed they do have soups and other foods that can be substituted on the house for all the diets residents receiving.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, facility failed to ensure the IHPs (Individual Habilitation Plans) for 3 of 12 sampled residents (Resident #4 & #7, #9) were followed with regards to providing physical therapy for Resident #4, the use of orthotic device for Resident #7 and ambulation for Resident #9. This failure placed Resident #7 at risk of right foot	W 249		

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W 249	Continued From page 7 contractures and Resident #4 and #9 ' s loss of ambulation ability. Findings Include: Observations, interviews and record reviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Resident #4 Resident #4 was observed in his wheelchair at his house. He used his feet to pull himself around the house while sitting in his wheelchair. Review of Resident #4 ' s records on 12/09/13 revealed he had [redacted] surgery on [redacted] 13. Records of follow-up visits to the surgeon ' s office on 02/27/13 and 03/27/13 revealed Resident #4 was to start Physical Therapy. Progress Notes written by Staff Y on 03/29/13, 04/10/13, and 08/08/13 revealed that by 08/08/13 Resident #4 could walk around the house unassisted and could walk longer distances holding on to someone ' s hand. Staff K (Registered Nurse) revealed in a 06/09/13 progress note and in the 10/31/13 Quarterly Nursing Review that Resident #4 is walking and making progress. Review of Ninety Day Healthcare Assessment by Resident #4 ' s physician dated 04/23/13 and 07/16/13 revealed that Resident #4 is able to walk independently and his gait is improving. Review of Resident #4 ' s AD Hoc IHP dated 09/20/13 revealed that Resident #4 could walk only with staff assistance with a gait belt. The 09/20/13 Ad Hoc IHP also revealed Resident #4 ' s physician was to write an order for the Physical	W 249	**W249 Program Implementation** For client #4, a current physician's order pertaining to Physical Therapy and Occupational Therapy per a 9/20/13 ad hoc will be completed. Completion 1/31/14 For client #4, the current Physical Therapy assessment per the 9/20/13 ad hoc will be filed. Completion 1/31/14 For client #7, an appointment for casting of her AFO is scheduled to ensure a proper fit. Once casting is completed, client #7 will be assessed as to when and duration of wearing the AFO. A tracking system will be developed to ensure use of AFO. Completion 2/28/14 For client #9, Percival staff will be in-serviced on SCP#1175 related to ambulating with the use of a gait belt. A tracking system will be developed to ensure occurrence of ambulation opportunities. Completion 2/14/14 All gait belt and AFO usage for clients on PAT A will be reviewed by the AC Manager to ensure proper fit and schedule being followed. AC Managers will then complete random observations monthly to ensure compliance. Completion 2/14/14 and Ongoing **Person Responsible** PCP, RPT, ACM **Monitor** PAT A DDA1 &DDA2	

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W 249	Continued From page 8 Therapist to assess Resident #4 quarterly. Also, Occupational Therapy would work with desensitizing Resident #4 to wearing a gait belt. Review of Resident #4 ' s record did not reveal any order for PT/OT pertinent to the 09/20/13 Ad Hoc. Review of the Resident #4 ' s records on 12/10/13 revealed no physician ' s order pertaining to Physical Therapy and Occupational Therapy as required by Resident #4 ' s Ad Hoc IHP dated 9/20/13. No record of a Physical Therapy assessment as required by the 09/20/13 Ad Hoc IHP was revealed in Resident #4 ' s records. Interview with Staff J (Physical Therapist) revealed she has not worked with Resident #4 since 03/18/13. Staff J stated during a 12/10/13 interview the Ad Hoc IHP only required quarterly assessments by her. Staff J stated that since the Ad Hoc IHP was dated 9/20/13, she was not required to do a Physical Therapy assessment of Resident #4 until 12/20/13. Resident #7: Observation revealed that resident was not wearing an AFO (Ankle Foot Orthotic) on her right foot. Resident #7 ambulated with a severe hunched over posture. Her right foot turns out so that resident ' s ankle rolls over so she was walking on the outside of her foot/ankle whenever she sets her foot down. Record review revealed Physicians Annual Health Care Assessment was completed on 09/20/13, revealed resident has significant equinus foot deformities especially on the right side and has been seen on several occasions in Orthopedic and Podiatry Clinics. She uses an AFO to prevent	W 249		

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W 249	Continued From page 9 progressive right foot contractures. Review of Resident #7 ' s nursing quarterlies did not identify any skin integrity issues to the right foot/ankle. Interview with Staff A revealed Resident #7 no longer wears the AFO and has not had it on in approximately a year due to skin integrity issues. Resident #9: Resident was laying on the small couch during observation period in the living room area in front of the television set, although he did not appear to be watching it. Resident #9 was watching and talking to the staff during this time. Resident #9 was observed only one time ambulating with a staff member with a gait belt, all other times Resident #9 was in a wheelchair, on the couch, or sitting at the dining table eating. During observation period resident was not observed being ambulated to the bathroom or room as prescribed. Review of IHP (09/03/13) revealed staff will assist resident to walk to/from ADL (Activity of Daily Living) tasks on the house, i.e. bathroom to bedroom/dining room; living room to bathroom, etc. to better ensure resident does not lose physical strength/skills, or develop health problems related to being sedentary. Documentation was not available that reflected staff were ambulating resident to/from ADL ' s on the house.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 10 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to collect data for the behavioral objectives identified in 1 of 12 sampled residents (Resident #12) and 9 of 35 expanded sample residents ' (Resident #39, #40, #41, #42, #43, #44, #45, #46, & #47) IHPs (Individual Habilitation Plans). This failure created an incomplete and inaccurate account of residents ' progress towards meeting their behavioral objectives. Findings Include: Record reviews and interviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Record review of Devenish Behavioral Log Binder revealed December data collection tracking sheets had not been placed in the binder; therefore staff were unable to document information regarding their observations of residents ' daily behavior. Interview of ACM, Staff H, revealed staff were expected to collect data and document resident behavior on the tracking logs throughout each shift. The treatment team uses this collected information in evaluating the goals and behavioral treatment plan for each resident. Staff H was unaware the December data collection tracking sheets had not been placed in the binder and reported it was his responsibility to ensure the tracking sheets were available to staff each month. Staff H revealed staff had not reported the tracking sheets missing. Staff H	W 252	**W252 Program Documentation** For clients #12, 39, 40, 41, 42, 43, 44, 45, 46, 47 Daily Behavior summary and adaptive behavior summary sheets will be filed and thereby available for staff use. Completed 12/11/13 For PAT A Devenish staff, inservice training will occur related to the need for data sheets and the process to follow if data sheets are not available. Completion 2/14/14 For all clients on PAT A requiring the need for daily behavior summary sheets and adaptive behavior summary sheets, the PAT Psychologist will electronically send to the AC Managers current daily behavior and adaptive replacement summary sheets at the time of the IHP/ad hoc or other needed change. AC Managers will ensure a minimum of three months of tracking sheets are located in the behavior tracking book. Completion 2/14/14 & ongoing **Person Responsible** PSY & ACM **Monitor** DDA1 & DDA2	

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W 252	Continued From page 11 acknowledged residents ' daily behavior and adaptive behavior summaries were not collected for ten days during the month of December. Data was not collected for the following: Resident #12: • Daily Behavior Summary- SIB (Self Injurious Behavior), Elopement and Actual/Attempted Pica • Adaptive Behavior Summary-Appropriate Communication Resident #39: • Daily Behavior Summary-Loud Pressured Speech and Preoccupation with An Imaginary Person • Relaxation Techniques Resident # 40: • Daily Behavior Summary-SIB, Syndrome Related Behavior and Communication Resident #41: • Adaptive Behavior Summary-Appropriate Communication • Stripping-intentional removal of clothes in socially inappropriate circumstances. Resident #42: • Adaptive Behavior Summary-Appropriate Communication • Syndrome Related Behaviors Resident #43: • Adaptive Behavior Summary-Social Activity Tolerance • SIB and Screaming Resident #44:	W 252		

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W 252	Continued From page 12 · Adaptive Behavior Summary-Appropriate Communication · SIB Resident #45: · Daily Behavior Summary-SIB and Aggression · Adaptive Behavior Summary-Relaxation Activity Participation Resident #46: · Daily Behavior Summary-Appropriate Leisure Activity · Flipping Socks/String or Similar Items · Clothes Grabbing Resident #47: · Adaptive Behavior Summary-Social Activity Tolerance · Daily Behavior Summary-Episodes of SIB	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, facility failed to ensure Annual Health Care Assessments were completed for 3 of 12 sampled residents (Resident #3, #6, & #9) for 2013 and Nursing orders were followed for 1 of 12 sampled residents (Resident #8) for providing supplemental nutrition. Failure to assure staff complete Annual Health Care Assessments and follow Nursing orders may result in a deterioration of the residents' overall health and well-being.	W 322		

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W 322	Continued From page 13 Findings include: Observations, interviews and record reviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Annual Healthcare Assessments: Review of records revealed Resident #3, #6, & #9 had Annual Health Care Assessments completed on 07/27/12, 07/20/12, and 11/13/12 respectfully. Record review revealed Annual Health Care Assessments were not completed in 2013 for Resident #3, #6, & #9. Nursing orders: Record review revealed resident is fed both by mouth and PEG (Percutaneous Gastrostomy) tube. She is on a 3500 calorie, chopped texture diet with thin liquids and receives 1 can of Jevity (a nutritional supplement) at 5:00 am, 6:00 pm and if she refuses or eats less than 50 % of meals. Nursing Review dated 12/04/13 revealed that Resident #8 ' s weight was less than IBW (ideal body weight) due to weight loss and poor appetite. The AC (Attendant Counselor) Nursing Orders revealed staff were to write the percentage of each meal taken. If resident refused a meal staff were write R=refused and document percent of snack taken (supplemental finger foods, if any) and notify nursing if client refused or ate less than 50% of meal so supplemental tube feeding (Jevity) could be given. Record review revealed Nursing Order and	W 322	**W322 Physician Services** For clients #3, 6, 9, physicals have been completed. Completion 12/23/13 All physicals for PAT A clients will be completed on an annual basis beginning 1/1/13. Completion 1/1/13 and Ongoing For client #8, Crystal House staff will be in-serviced on proper documentation of nursing orders related to the amount of food client #8 eats each meal. Completion 1/31/14 For client #8, nursing staff will be in-serviced on proper documentation related to receiving supplemental Jevity. Completion 1/31/14 PAT A direct care staff will be in-serviced on proper documentation on nursing orders. Completion 2/14/14 PAT A nursing staff will be in-serviced on proper documentation for all PAT A clients receiving supplemental enteral feeding. Completion 2/14/14 PAT A ACM's and PCN's will monitor the nursing order form twice monthly to ensure compliance. **Person Responsible** PCP, PCN,ACM **Monitor** DDA1 & DDA2	

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W 322	Continued From page 14 Treatment Record documentation, Resident #8 refused 42 meals out of 103 meals for November 1 through December 11, 2013 and at 50% or less for 6 meals in November and 3 meals in December up to December 11, 2013. Documentation revealed Resident #8 did not receive her supplemental Jevity for 27 meals in November and December 2013. Interview with Staff E revealed she was not aware Resident #8 had not received the Jevity as ordered. When shown documentation on the Nursing Order and Treatment Record, Staff E acknowledged there were days where documentation was missing and/or supplements not given for times ordered.	W 322		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review, facility failed to ensure evacuation drills on the afternoon shift varied and were conducted under conditions which may actually occur during a fire on that shift. Failure to ensure the evacuation drills are conducted under varied and realistic conditions puts the residents at risk of harm should an emergency occur that necessitates evacuation. Fire evacuation drills at living units 2010 A and 2010 B on the afternoon shift were held at 3:00 PM on 01/17/13, 3:30 PM on 04/24/13, 3:10 PM on 07/23/13 and 3:25 PM on 10/09/13. Fire evacuation drills at Haddon House on the	W 441	**W441 Evacuation Drills** For houses 2010A, 2010B and Haddon, AC Managers will receive inservice training related to fire drills being per schedule under varied and realistic conditions. Completion 2/14/14 All PAT A house Managers will ensure completion of fire drills per schedule under varied and realistic conditions beginning 1/1/14. Completion 2/14/14 and Ongoing **Person Responsible** ACM **Monitor** DDA1 & DDA2	

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W 441	Continued From page 15 afternoon shift were held at 2:35 PM on 01/29/13, 2:35 PM on 04/30/13, 3:00 PM on 07/23/13 and 2:50 PM on 10/14/13.	W 441		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to observe infection control practices when staff failed to change gloves while serving food to residents in Devenish and Cascade, and failed to clean safety belts in Crystal and Naches. This failure placed residents at risk for illness due to exposure by cross contamination. Findings include: Observations and interviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Cascade: Observation of breakfast on 12/07/13 revealed Staff M, Staff N, Staff O and Staff P failed to change gloves between tasks after staff wiped residents' mouths and laps and served hand over hand assistance. Observation of breakfast on 12/09/13 revealed Staff Q, Staff R and Staff S failed to change gloves between tasks after staff wiped residents' mouths and laps and served hand over hand assistance. Devenish:	W 455	**W455 Infection Control** Staff working on PAT A Houses Cascade and Devenish, will be in-serviced regarding changing gloves between tasks. Completion 1/31/14 Staff working on Crystal and Naches will be in-serviced on cleaning the seat belts of dining room chairs, recliners, sofas and toilets between residents. Completion 1/31/14 All PAT A direct care staff will be in-serviced on changing gloves between tasks as a means to prevent/control infectious diseases. Completion 2/14/14 All PAT A direct care staff will be in- serviced on cleaning the seat belts of dining room chairs, recliners, sofas and toilets between client usage. Completion 2/14/14 AC Managers will complete a minimum of 10 observations per month to ensure appropriate precautions are being taken related to infection control. Completion 2/14/14 and Ongoing **Person Responsible** ACM **Monitor** DDA1 & DDA2	

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W 455	Continued From page 16 Observation of lunch on 12/07/13 revealed Staff T, Staff U and Staff V failed to change gloves between tasks after staff provided hand over hand assistance to residents, wiped residents' mouths and laps and wiped up food that had spilled to the floor. Crystal: Observation of dining room chairs, recliners, sofas, and toilets with seat belts revealed that they were not being cleaned between residents during the observation period of 12/06/13, 12/08/13, 12/09/13, and 12/10/13. No cleaning product was available for staff to clean the belts in between residents. Interview of house staff revealed that many did not know that they were to clean the belts between residents. Others stated that night shift cleans the belts with Virex solution and still others stated that the belts are cleaned between residents with the Attend Wipes. Naches: Observation of toilets and dining room chairs were noted not to be cleaned during the observation period of 12/07/13, 12/09/13, and 12/11/13. Staff A stated that the staff uses Virex to clean the belts between residents. Staff F stated that Night shift is in charge of cleaning the seat belts in the bathrooms on a nightly basis and interview with Staff B revealed she did know how they were to clean the belts.	W 455		
W 471	483.480(b)(1)(ii) MEAL SERVICES Each client must receive meals with not less than 10 hours between breakfast and the evening meal of the same day, except as provided under	W 471		

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W 471	Continued From page 17 paragraph (b)(1)(i) of this section. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, facility failed to ensure 3 of 12 sampled residents (Resident #8, #9, & #12) and 3 of 35 expanded sample residents (Resident #13, #39, & #41) received the diet prescriptions as ordered. This failure placed residents at risk of compromised health. Findings include: Observations, interviews and record reviews were conduoted 12/06/13 through 12/11/13 unless otherwise specified. Crystal: Observations of meals at Crystal revealed residents were not being serving the appropriate amount of food as required by the dietician evaluations. Resident #8 is on a 3500 calorie chopped diet and on 12/06/13 at lunch she was to receive 6 oz of cut up ham, 2 cups of au gratin potatoes, 1 cup of broccoli Normandy and ½ cup of pears. Resident #8 received ½ cup of au gratin potatoes, 4 oz of ham, ½ cup broccoli and ½ cup of pears. Resident ate the ham, potatoes and pears and left the vegetable. Resident #9 is on a 2200 calorie chopped diet and on 12/06/13 at lunch he was supposed to receive 3 oz of chopped ham, 1 cup au gratin potatoes, ½ cup broccoli Normandy (ground) and ½ cup pears. Resident received 8 oz of chopped ham, 1 ½ cups au gratin potato, 1 cup of broccoli and a 1 cup of pears.	W 471	**W471 Meal Services.** For clients #8, 9, 13: Crystal House staff will be in-serviced on correct dietary portions. For clients#12, 39, 41: Devenish House staff will be in-serviced on correct dietary portions. Completion 1/31/14 PAT A direct care staff will be trained on how to correctly use the measuring spoons in relationship to the caloric requirements. Completion 2/14/14 PAT A AC Managers will monitor a minimum of 10 meals per month to ensure correct caloric amounts are given to PAT A clients. Completion 2/14/14 & Ongoing **Person Responsible** ACM. **Monitor** DDA1 &DDA2	

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W 471	Continued From page 18	W 471		

Resident #13 is on a 3500 calorie chopped diet and on 12/06/13 at dinner he was to receive 2 cups of minestrone soup, 2 tuna salad sandwiches, 1 cup of milk, and ½ cup of Jell-O. He only received 1 cup of the soup and 1 sandwich, a cup of sliced pears, a 4 oz glass of skim milk and a 4 oz glass of sugar free drink.

Interview with dietician Staff G revealed staff has been trained as to how much each resident is to receive for their respective diets.

Devenish:

Observation of lunch on 12/07/13 revealed. Resident #12 received unmeasured portion sizes which differed from prescribed diet and the dietary menu and portion instructions provided by the registered dietician.
Rainier School Food and Nutrition Client Dietary List revealed Resident #12 has a 2200 calorie, ground diet prescription.

Dietary menu and portion instructions for lunch on 12/07/13 revealed the following serving size: 2200 calorie diet: 1 cup beef, 1 bun, ½ cup potato and ½ cup vegetables.

During this lunch service Resident #12 received 2 scoops of unmeasured meat, one unmeasured serving of mixed vegetables and one unmeasured scoop of potato. A second helping of food was provided to Resident #12 which included one additional unmeasured scoop of ground meat, mixed vegetables and potatoes.

Observation of lunch on 12/07/13 and breakfast on 12/10/13 revealed Resident #39 received

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W 471	Continued From page 19 unmeasured portion sizes which differed from prescribed diet and the dietary menu and portion instructions provided by the registered dietician. Rainier School Food and Nutrition Client Dietary List revealed Resident #39 has a 1500 calorie, ground diet prescription. Dietary menu and portion instructions for lunch on 12/07/13 revealed the following serving size: 1500 calorie diet: ½ cup beef, 1 bun and ½ cup potato, ½ cup vegetables. Observation during lunch revealed Resident #39 received 2 scoops of unmeasured meat, and one scoop of unmeasured mixed vegetables and one scoop of unmeasured potato. A second helping of food was provided to Resident #39 which included one additional unmeasured scoop of ground meat, mixed vegetables and potatoes. Dietary menu and portion instructions for breakfast meal on 12/10/13 revealed the following serving size: 1500 calorie diet: ½ cup fruit, 1 pancake. Observation during breakfast revealed #39 received one pancake and a scoop of unmeasured fruit. Resident #39 was served a second helping which included a second pancake and another unmeasured scoop of fruit. Observation of lunch on 12/07/13 revealed Resident #41 received unmeasured portion sizes which differed from prescribed diet and the dietary menu and portion instructions provided by the registered dietician. Rainier School Food and Nutrition Client Dietary List revealed Resident #41 has a 2200 calorie, ground diet prescription.	W 471		

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W 471	Continued From page 20 Dietary menu and portion instructions for lunch on 12/07/13 revealed the following serving size: 2200 calorie diet: 1 cup beef, 1 bun, ½ cup potato and ½ cup vegetables. Observation during lunch revealed Resident #41 received 2 scoops of unmeasured meat and one unmeasured serving of mixed vegetables. A second helping of food was provided which included one additional unmeasured scoop of ground meat and mixed vegetables. Interviews revealed staff were unaware of the measurement requirements and the caloric requirements for the three residents. Staff were unable to report the measuring size of each serving spoon and revealed it was a best guess for the serving size. Staff H (ACM) reported the staff didn't always use the measuring serving spoons but believed staff were providing an accurate servings based on individual resident dietary needs.	W 471		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve a prescribed diet of ground textured food during two meals for 1 of 12 sampled residents (Resident #12). This failure caused Resident #12 to be served food that was not appropriate size or texture for his eating and swallowing ability, placing resident at risk of harm of choking and/or aspiration.	W 474	**W474 Meal Services** For client #12, Devenish House staff will be trained on correct food texture and bite size per prescribed diet order. Completion 1/31/14 For all clients on PAT A, direct care staff will be trained on food textures and bite size per prescribed order as noted in the house diet books. Completion 2/14/14 PAT A AC Managers will monitor a minimum of 10 meals per month to ensure correct bite size and textures are being given to PAT A clients. Completion 2/14/14 & Ongoing **Person Responsible** ACM **Monitor** DDA1 & DDA2	

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W 474	Continued From page 21 Findings Include: Observations, interviews and record reviews were conducted 12/06/13 through 12/11/13 unless otherwise specified. Record review of the Annual Health Care Assessment, dated 11/02/12, revealed a prescribed modified textured, ground diet due to Resident #12 ' s history of dysphagia (difficulty with swallowing). Rainier School Standard Operating Procedures 4.07- Appendix A (dated 03/09) revealed a ground diet should be: • Food pieces no larger than ¼ inch in diameter-Soft and easy to mash. • No bread unless crust removed, soaked and cut into 16 pieces Observation of Resident #12 during lunch meal on 12/07/13 revealed resident was served ground beef served in a hamburger bun. The bun was cut into 1 inch pieces but was not moistened or soaked with any liquid. Observation of Resident #12 during breakfast meal on 12/08/13 revealed resident was served a pancake and a fruit Nutri-Grain cereal bar, each cut into 1 inch pieces. The staff poured soy milk onto the pancake and cereal bar and the resident began eating the pancake and cereal bar pieces prior to the food items becoming a moist or soaked texture. The dietician menu directions for the 12/08/13 breakfast revealed " House Modify " instructions to cut and soak the pancakes.	W 474		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	Continued From page 22 Interview of Staff H (ACM) revealed he believed staff were following the diet plan but may not be not fully aware of the method for ensuring a ground diet.	W 474		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

February 28, 2013
CERTIFIED MAIL (7007 1490 0003 4200 5525)

Neil Crowley, Superintendent
Rainier School PAT A
PO Box 600
Buckley, Washington 98321

RE: Recertification Survey
2/5/2013 through 2/11/2013

Dear Mr. Crowley:

From 2/5/2013 through 2/11/2013, ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey and a Complaint Investigation (2751053) conducted at Rainier School PAT A on 2/5/13 to 2/8/13 & 2/11/13. A sample of 12 residents was selected from a census of 122. The Expanded Sample included 81 current residents. The survey was conducted by: Janette Buchanan, R.N., B.S.N. Penelope Rarick, B.A. Christina Borchardt, R.N., B.S.N. Claudia Baetge, M.A. The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Servey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-2419 Fax: (360) 725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation the facility failed to maintain food storage and sanitation in 5 of 6 cottages (Naches, Haddon, Percival, Devenish,	W 104	**W104 – Food Storage and Sanitation** Appropriate food storage and sanitation will be maintained. Immediate disposal of outdated food products occurred on the PAT A Houses as well as the Coffee Shop.	Completed 2/08/13

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 3/15/13

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rticipation.

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104	Continued From page 1 and Buckley) and the Coffee Shop. Failure to ensure food sanitation and storage was maintained potentially exposed residents to foodborne illnesses. Findings include: Buckley Kitchen 02/05/13 Refrigerator: 1. Burned out light bulb 2. Mustard, expired 04/26/12 3. 6-½ pint Meadowsweet Farms skim milk, expired 02/02/13 4. Plastic tub of unidentified food (lettuce), brown with slimy coating, unlabeled, undated 5. Plastic tub of unidentified food, (brownish, gelatin?), unlabeled, undated Freezer: 1. Unidentified food product (French toast?), unlabeled, undated 2. Unidentified food product, freezer burn, unlabeled, undated 3. Unidentified food product (meat patties?), bag ripped, unsealed, unlabeled, undated 4. Several bags of unidentified food product (sliced meat?), unlabeled, undated 5. Unidentified food product (sausage?), bag ripped, unsealed, unlabeled, undated 6. Unidentified food product (pancakes?), unlabeled, unsealed 7. Unidentified food product (dessert cake?), unlabeled, unsealed Pantry: 1. Opened bread, unsealed, undated 2. 2 bottles Mustard, expired 12/09/12 & 2/22/12 3. Unidentified liquid in container, (syrup?),	W 104	All food products will be labeled, identified and dated. Additionally, all food products will be rotated on the "first in first out" process. Staff training will be completed regarding the first in first out process. Only food products and kitchen appropriate equipment will be kept in kitchen cupboards. Additionally, kitchen cupboard handles will be maintained in good repair. Staff training will be completed regarding appropriate storage in cupboards. For PAT A Houses, AC Managers will monitor on a weekly basis to ensure food products are appropriately labeled, identified and dated. For the Coffee Shop, the ATS3 will be inserviced on monitoring to ensure daily/weekly/monthly cleaning schedule is completed. **Person Responsible** ACM/ATS3 **Monitor** PAT A DDA2 & Adult Training Operations Manager	Completed 3/31/13 Completed 3/18/13 Ongoing Completed 3/18/13

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W 104	Continued From page 2 unlabeled, undated 4. Opened bag of raisins, undated 5. Opened bag of crackers, unsealed, undated Devenish kitchen 02/05/13 Refrigerator: 1. 3 bottles Mustard, expired 09/26/12 & (2) 12/31/12 2. Jar, labeled with ".mayonnaise- for everyone ", no original factory label, no expiration date available, undated 3. Party fruit tray, undated 4. Party cheese and cracker tray, undated 5. Plastic container with unidentified product (spaghetti?), unlabeled, undated Freezer: 1. 6 -1 lb. margarine blocks, unopened, undated 2. Unidentified meat product, (meat patties?), unlabeled, undated 3. 2 plastic bags of unidentified meat product, (sausage links), unlabeled, undated 4. 5 bags of unidentified product, (cookies?); unlabeled, undated 5. 1 bag of an unidentified food product (French toast?), unlabeled, undated 6. 5 bags of unidentified food product (dessert?), unlabeled, undated Pantry: 1. 2 unidentified bottles of liquid (syrup?), unlabeled, undated 2. Package of Hormel Complete Eats Spaghetti, expired 06/30/12 3. 2 bottles Mustard, expired 12/31/12 4. Chicken In A Biscuit, opened box, undated 5. 2 Jello Pudding mix, expired April 2012 & June 2012	W 104		

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V 104	Continued From page 3 Haddon Kitchen 02/05/13 Kitchen refrigerator 1. Smuckers grape jelly, open, expiration 11/11/12 2. Ranch dressing, open, undated 3. 3 bottles Mustard, open, expiration 5/11 & (2) 10/26/12 4. Creamy home style frosting, open, undated 5. Powerade (1 bottle), open, undated 6. Carrots (bag), open, undated 7. Rotten apple in bag, contaminated other apples 8. Baked potatoes (3), undated 9. Thickened apple juice, open, undated 10. Unidentified liquid in unmarked sealable dish (maple syrup?), unlabeled, undated 11. Ensure pudding, open, undated Kitchen cupboard 1. Goldfish box, open, undated 2. Nacho seasoning, expiration 8/4/10 3. Small cup of unknown white substance 4. Nilla wafers, 1 ½ bags, open, undated 5. Ginger (2), Cinnamon, Ground nutmeg, Paprika, Poultry seasoning, open, undated 6. Cloves, expiration 10/04 7. Plastic cup of unknown spices (cinnamon/sugar mix?), unlabeled 8. Open bag if crackers, unsealed, undated 9. Marshmallows, open, undated 10. 2 Clear containers with unlabeled seasoning (pepper? & Cinnamon?), open, undated 11. Tube icing, open, undated 12. Confetti frosting, open, undated 13. Johnny ' s seafood seasoning, open, undated	W 104		

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W 104	Continued From page 4 14. Unknown spice, undated 15. Baby food jar with unknown spice (pepper?), unlabeled, undated 16. 3 Popcorn seasonings, expiration 2/10/10 & 2/17/10, unopened & 1/20/10, open, undated 17. Soy sauce, open, undated 18. Graham crackers, open, undated, expiration 10/2011 19. Sprinkles, open, undated 20. Red crystals, green crystals, holiday berry crystals, open, undated 21. 4 blue, 1 Green food coloring, open, undated 22. Unknown substance (oatmeal ?), undated, unlabeled 23. Oatmeal, open, undated 24. Cocoa puffs, open, undated 25. Cheerios, open, undated 26. Popcorn, open, undated 27. Unknown white powdery substance, open, undated 28. Corn starch, open, undated 29. 2 Shortening (48oz), open, undated 30. Corn meal, open, undated 31. Blueberry muffin mix, open, undated 32. Buttermilk pancakes, open, undated, expiration 2/12/08 33. Vegetable oil, expiration 5/14/12 34. Flour, open, undated 35. Baking soda, open, undated 36. Brown sugar, open, undated 37. Sugar, open, undated 38. Salt, open, undated 39. Honey, open, undated 40. Smuckers strawberry jelly, open, undated 41. Yellow cake mix, expiration 9/22/12 Kitchen cupboard near medication room	W 104		

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' 104	Continued From page 5 1. 6 tubes of sunscreen 2. Elmer ' s glue bottle 3. White board cleaner, spray bottle 4. Broken handle (cupboard) to right of sink Freezer -chest 1. French fries (bag), open, undated 2. Unidentified food product (2 chicken breasts?) in plastic zip bag, undated, unlabeled 3. Unidentified food product (Ribs?- 2 bags), undated, unlabeled 4. Unidentified food product (Corn dogs?), 1 bag, undated, unlabeled 5. 1 corn dog (not in bag), on bottom of freezer 6. Unidentified patties (Sausage?) (2 bags),undated, unlabeled 7. Unidentified patties (Chicken?) (3 bags), undated, unlabeled 8. 1 frozen strawberry (loose on bottom of freezer) 9. Mixed vegetables, 1 bag, open, undated 10. Unidentified food product (Cookie dough?), 1 bag, undated, unlabeled 11. Unidentified food product (Muffins?), 1 bag, undated, unlabeled 12. Unidentified patties (Sausage?) (1 bag), open, undated, freezer burn 13. Ground beef (5lbs), open, undated 14. Strawberry ' s, hole in bag, open, undated Naches Kitchen 02/06/12 Refrigerator 1. Coffee creamer, open, undated 2. Hershey chocolate syrup, open, undated	W 104		

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W 104	Continued From page 6 3. Smuckers grape jelly (2), strawberry jelly (1), open, undated 4. Mustard, open, undated 5. Pancake syrup, open, undated 6. 2 containers of syrup, open, undated 7. Horseradish, open, undated 8. 1 egg 9. Pepsi, unlabeled, unopened 10. Treetop juice- thickened juice, undated 11. Rejuv prune juice, open, unlabeled 12. Water bottle, unlabeled, unopened 13. Jalapenos, open, undated 14. Unidentified meat in Rubbermaid container 15. Unknown white substance in unlabeled container, undated, open 16. Salami, ½ stick, open, undated 17. Cheese, open, undated 18. Unidentified food product (Stuffing?), in zip seal bag, open, undated 19. Unidentified food product (Ritz crackers), undated, unlabeled, unsealed 20. 6- ½ sandwiches (premade), undated 21. Fruit punch flavored water, unlabeled Kitchen Refrigerator Freezer 1. 2 unknown substances in square Rubbermaid containers, open, undated 2. Unidentified food product (6 Pancakes?), in sandwich bag, undated, unlabeled 3. Unidentified food product (Pancake?), 17 bags, undated, unlabeled 4. Frozen water bottles (3), unlabeled 5. Frozen bottle of unknown fluid, unlabeled 6. Moldy frozen hotdog buns (2), open, undated 7. Unidentified food product (5 French toast?), undated, unlabeled 8. Unidentified food product (1 sausage patty?),	W 104		

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/ 104	Continued From page 7 undated, unlabeled 9. Frozen bottle of Pepsi Cupboard 1. Unidentified food product (Macaroni?), in plastic bag, open, undated 2. Signature syrup, expiration 1/19/13 3. Crispix cereal, expiration 11/9/12 4. Unidentified food product (Nilla wafers?), partial bag, unsealed, undated, unlabeled 5. Grated parmesan cheese, open, undated 6. Tootsy O ' s & Frosted flakes (3), packaged cereal, open, undated 7. Unidentified food product (Instant mashed potatoes?), in zip seal bag, undated, unlabeled 8. Krusteaz blueberry muffin mix, open, undated 9. Gold fish box, open, undated 10. Blueberry syrup (for coffee flavoring), open, undated Cupboard near stove 1. 3 partial bags wheat bread, open, undated, unsealed 2. Open bag of crackers (saltines), undated 3. Peanut butter, open, undated 4. Honey, open, undated 5. Flour, open, undated 6. Allspice, Paprika, Ginger, Cloves, Oregano, Nutmeg, Cinnamon, Crushed red pepper, Season salt, Italian seasoning, Onion Salt, Mrs. Dash 6.7 oz, Chili Powder, Garlic powder, Lemon pepper (2), Baking soda (2), Sugar in bag (leaking), Brown sugar, open, dated 7. Pumpkin spice, open, expiration 5/94 8. Ginger, open, expiration 10/97 9. cloves, open, expiration 10/97	W 104		

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W 104	Continued From page 8 10. Sage, open, expiration 11/97 11. Syrup (2), open, undated (one expired 01/6/12) 12. Christmas mix sprinkles, Confetti sprinkles, Variety sprinkles, Sprinkles (red)(2), Green sprinkles, Yellow sugar crystals, open, undated 13. Cappuccino, undated 14. Taco seasoning (2), open, undated 15. Ice tea drink mix, open, undated 16. Food coloring, (4 packages), open, undated 17. Unidentified food product (Brown sugar? Sugar? Blue container with rice?, coffee jar with Vanilla?, mason jar with Chocolate chips?, & 2 Powdered sugars?) unsealed, unlabeled, undated 18. Unidentified food product (Flour, sugar, oatmeal, corn starch/ brown sugar?) in Thickit tubs, undated, unsealed, unlabeled 19. Brown gravy mix, open, expired 11/4/10 20. Salad dressing, open, undated 21. Shortening, open, undated 22. Nesqick, open, expiration 8/12 23. 4 Evaporated canned milk, expiration 5/4/11, 6/18/11 & 4/1/12 (2) 24. Unidentified liquid (Molasses?), undated, unsealed, unlabeled 25. Fiber Basic (above stove), open, undated 26. Vegetable soup (1 gallon), expiration 10/31/12 27. Tomato soup (1 gallon), expiration 10/27/11 & 3/14/12 28. Thick and Easy, open, undated 29. Chef Boyardee (2 large cans), expiration 11/12/12 Percival Kitchen (02/05/13): Kitchen Refrigerator: 1. Mustard, expiration 12/13/12	W 104		

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V 104	Continued From page 9 2. Italian Salad Dressing, 11/27/11 expiration date 3. Longhorn BBQ sauce, 5/22/12 expiration date 4. 3 plastic containers with unidentified food item, unlabeled, undated Freezer: 1. Unidentified product (chicken nuggets?), unlabeled, no protective freezer bag, undated 2. 2 packages of unidentified product (hash browns?), paper back, torn, unsealed, unlabeled, undated 3. Unidentified product (chicken?), unlabeled, undated 4. 4 loaves of bread (2 wheat & 2 white), undated 5. Unidentified product (meat?), opened plastic, not sealed, undated 6. Foiled covered product, labeled ham, date not legible 7. 2 packages of 5 quantity, unidentified products (meat patties?), unlabeled, undated 8. 2 packages of unidentified product (sliced cheese?), no freezer protective wrap, unlabeled, undated Pantry: 1. Vanilla wafer cookies, opened bag, unsealed, undated 2. Signature Creamy Peanut Butter, opened container, undated 3. Goldfish crackers, opened box, undated 4. 6 wrapped muffins, unlabeled undated 5. 2 piece of yellow cake, unlabeled, undated 6. One pastry item, unlabeled, undated 7. Plastic tub of unidentified product (margarine?), unlabeled, undated 8. 2 packages of crackers, opened, unsealed,	W 104		

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W 104	Continued From page 10 undated 9. 1 package of bread, unsealed, 2-3 slices, undated 10. Industrial size can of pineapple, expiration 6/22/11. Coffee Shop 02/06/13: Chest Freezer 1. Bread cream cheese box, open, undated 2. Curly fries, open bag, expiration 8/2/12 3. Bag of tater tots, open, undated 4. Tater tots, loose out of bag (5) 5. Dill pickle spears, expiration 5/10/12 6. Mozzarella cheese sticks, open, undated 7. Mushrooms, 1 large bag, open, undated 8. Mini taco ' s (in square gallon container), not covered, unlabeled, undated 9. Bag of min taco ' s.(3) gallon bags, open, undated 10. Bag of mini burritos (2) gallon bags, open, undated 11. Bag of sweet potato fries, open, undated Upright freezer 1. Bread squares in Ziploc bag, undated 2. Shredded parmesan cheese, open date 11/6/12 3. Blue cheese crumbles, expiration 3/12 4. Feta cheese crumbles, expiration 8/12 5. Mushrooms in large zip closure bag, undated 6. Unidentified product (shredded carrots?), undated 7. Mozzarella cheese, open date 11/1/12 8. Swiss cheese in zip closure bag, open, undated	W 104		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 11 9. Fish sticks (2 bags), open, undated 10. Andaville sausage, 7/23/12 open date 11. Hamburger patties, open, undated 12. Unidentified food product (Mushrooms?) in zip closure bag, freezer burned, undated 13. Unidentified food product (2 Chicken strips), undated, unsealed, unlabeled 14. Peas, open, undated 15. Bag of unknown substance 16. Unidentified food product (6 Hamburger patties?),freezer burned, undated, unlabeled 17. Coconut, shredded (1 bag), open, undated 18. Sausage dogs, open, undated 19. Vanilla glaze, open, undated 20. Passion fruit glaze, open, undated 21. Unidentified food product (3 Hamburger patties?), undated, unsealed, unlabeled 22. Fruit cocktail, open, undated Large upright freezer 1. Cookie dough (4) undated 2. Onions (bag), 12/23/13 best used by date 3. Onions (large bag), open, undated 4. Garden burgers, open, undated 5. Garden burgers, 3/29/12 best used by date 6. Beef frankfurter (1), open, undated 7. Pepperoni, open, undated, freezer burn 8. Salami, open, undated 9. Hoagie rolls, open, undated 10. Gluten free muffins, open, undated, ice on them 11. Unidentifiable substance (long thin meat?), open, undated 12. Croissant (6), open, undated Small freezer above refrigerator	W 104		

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W 104	Continued From page 12 1. Sunflower seeds (1 large bag & 1 small bag), open, undated. 2. Peas, open, undated 3. Pecan pieces, expiration date 4/12/12, open, undated 4. Walnuts, Almonds, open, undated 5. Ocean spray sweetened dry cranberries, open, undated 6. Frozen pasta tortellini, open, undated 7. White chocolate chips,(1 large bag & 1 small bag), open, undated 8. Chocolate chips, gallon bag, open, undated 9. Raspberries (2 bags), open, undated Refrigerator 1. Cocktail sauce, 1 gallon, open, undated 2. Horseradish, open, undated 3. Buffalo wing sauce, expiration 8-2011, undated 4. Mr. Whip, open, undated 5. Sweet pickle relish (1 gallon), open, undated, 8/8/12 best used by 6. Sandwich sauce, open, undated 7. Hazen sauce, expiration date 11/18/11, open, undated 8. Gruyere cheese, partial block, open, undated 9. Pepperchinis, open, undated 10. Salad dressing, expiration 10/4/2012, dated 11/16/12 11. Cocktail sauce (gallon), expiration 5/13/12 12. 1 quart unidentified substance(gravy?), open, undated, unlabeled 13. Steve ' s hot smoked cheese, open, undated 14. Roasted beef Au Jus, open, undated 15. 1 quart unidentifiable sauce (red berry?), open, undated, unlabeled 16. Chipotle sauce, expiration 10/25/12	W 104		

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V 104	Continued From page 13 17. Beef base, unopened, expiration 4/12/12 18. Ham base, expiration 12/20/12 19. Chicken base, expiration 11/29/12 20. Monterey Jack with jalapeno pepper cheese, partial block, open, undated Shelves 1. Knorr mousse, not dated 2. Peanut butter jars (3), expiration 1/14/13 3. Cheddar Sun chips (large bag of individual serving bags); best if used by date 1/1/13 4. Shelves dirty, sticky 5. Sauerkraut jar top, dirty (black substance on lids)	W 104		
' 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review the facility failed to ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, were reported immediately to the facility administrator and Complaint Resolution Unit (CRU) for 1 of 12 sample residents (Resident #3) and 3 of 81 expanded sample residents (Resident #14, 65 & 78). Failure to make timely reports prevented the facility and State Investigative Agency from having immediate knowledge of an incident, which placed the residents at risk of abuse or harm.	W 153	**W153 Staff Treatment of Clients** All allegations of observed injuries to vulnerable body parts and injuries of unknown origin will be called to CRU within 24 hours. Staff will be retrained regarding immediate calling to CRU for all injuries to vulnerable body parts and injuries of unknown origin. **Person responsible:** AC Manager **Monitor:** PAT A DDA2	Ongoing 3/31/13

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W 153	Continued From page 14 Findings include: Record review on 02/05/13 & 02/06/13 of facility's last six months (August 2012 to January 2013) incident and investigation documentation revealed that the facility and CRU were not notified immediately after the incident occurred on the following incidents: • Resident #3 sustained an injury to a vulnerable part of the body on 11/13/12 but incident was not reported to the appropriate authorities until 11/26/12. • Resident #14 sustained an injury of unknown origin reported on 02/03/13 although incident potentially occurred during a bath on 02/02/13 when resident was having behaviors that were not documented. • Resident #65 sustained an injury to a vulnerable part of the body on 08/19/12 but incident was not reported to the appropriate authorities until 09/04/12. • Resident #78 sustained an injury to a vulnerable part of the body on 11/22/12 but incident was not reported to the appropriate authorities until 11/26/12.	W 153		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation and record review the	W 263	**W263 Program Monitoring and Change** All guardians for PAT A clients will be receiving a written consent letter related to locking knives. Additionally, HRC will receive the signed letter (when returned by guardian) for review.	Ongoing

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V 263	Continued From page 15 facility failed to obtain written consents prior to implementation of restrictive programs with regards to locking up knives in 6 of 6 cottages (Buckley, Devenish, Haddon, Klamath, Naches, & Percival), motion alarm sensors for 2 of 81 expanded sample residents (Resident #42 & 87), and Individual Habilitation Plan (IHP) for 1 of 12 sample residents (Resident #3). This failure denied the resident/guardian the opportunity to make informed decisions about facility restrictive programs. Findings include: All observations were on 02/05/13 to 02/08/13 unless otherwise stated. Kitchen Knives: Observation of six cottages (Haddon, Devenish, Buckley, Percival, Naches, and Klamath) during environmental rounds revealed all sharp knives were locked up in the kitchen area and not accessible for resident use. Interviews on 02/06/13 with the Attendant Counselor Managers (ACM) of Devenish, Buckley and Percival revealed they had not obtained written consents approving the restrictions. Motion Alarm Sensors: [redacted] House: Observation of Resident #42's room noted the motion alarm sensor in place and working. Record review of residents whose bedrooms contain motion alarm sensors revealed Resident #42 had no signed consent from a legal guardian approving the restrictive device. The legal guardian had given verbal approval for the motion alarm sensor on 09/12. Facility failed to obtain a signed copy of the consent form from	W 263	For resident #42, a signed consent form related to his motion sensor will be completed and resubmitted to guardian for signature. Upon return, the signed consent form will be filed. For resident #87, a signed consent form related to her motion sensor will be completed and submitted to guardian for signature. Upon return, the signed consent form will be filed. For resident #3, a signed consent form related to IHP approval will be completed and resubmitted to guardian for signature. Upon return, the signed consent form will be filed. For all clients on PAT A, the following procedure will be initiated: • All consents will be tracked by the PAT A secretary. • All consents will be filed by the HPA/PSY within 30 days of receipt. • DDA1 will complete random monthly file reviews to ensure consents are current and in file. **Person Responsible** DDA1 **Monitor** DDA2	Completed 2/22/13 Completed 3/31/13 Completed 2/14/13 Ongoing

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W 263	Continued From page 16 guardian. [redacted] House: Observation on 02/06/13 of Resident #87 ' s room noted the motion alarm sensor in place and working. Record review of residents whose bedrooms contain motion alarm sensors revealed Resident #87 failed to have signed consents from HRC and legal guardian related to use of a motion alarm sensor. Individual Habilitation Plan (IHP) failed to list the motion alarm sensor as a restrictive device. Staff interviews revealed the motion alarm sensor had inadvertently been left in use for the past 1-1 ½ years, after the program had determined it was no longer necessary. On 02/07/13 staff disabled the motion alarm sensor by removing the batteries. Individual Habilitation Plan: Record review for Resident #3 revealed his annual IHP, dated 12/06/12, failed to have the signature of his legal guardian approving restrictive programs. These restrictive programs included a diet modification plan, a dental health related protection plan, tilt in space wheelchair with safety belt, Geri chair with safety belt, soft helmet and personal mail. Staff interviews confirmed facility failed to obtain guardian ' s signature for the most recent IHP.	W 263		
W 334	483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination.	W 334	**W334 Nursing Services** Residents #1,2,3,4,5,6,7,8,9,10,11,and 12 will have direct nursing physical exams completed, documented and filed. All RN staff with primary care nurse duties will be trained to complete, document and file a direct physical exam in conjunction with the Nursing Quarterly Review.	Completed 3/31/13 Completed 3/31/13

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W 334	Continued From page 17 This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to perform direct physical examination for Quarterly Nursing Reviews for 12 of 12 sample residents and complete Quarterly Nursing Reviews for 6 of 12 sample residents (Resident # 1, 2, 4, 5, 8, & 11). Failure to perform direct physical examinations did not ensure accurate nursing assessments placing residents at risk for unmet nursing care needs. Findings include: Record review on 02/06/13 to 02/08/13 quarterly nursing assessments had not been completed for 6 of 12 sample residents. 4 of 12 sample residents (Resident #1, 2, 4 & 5) were missing their 2nd quarter nursing review. 5 of 12 sample residents (Resident #1, 2, 4, 8 & 11) were missing their 4th quarter nursing review. Interviews of nursing staff on 02/07/13 revealed the facility was not consistently performing a full head to toe examination on each resident for the quarterly physical examination: Staff interviews revealed information for the quarterly review is often gathered through a resident record review. Medical staff on 2010A and 2010B stated they do not consistently perform a full head to toe examination for the resident's quarterly physical examination as they provide resident care to the residents on a daily basis. Upon review of the facility's Quarterly Nursing Review form it was difficult to determine whether or not a direct physical examination had been	W 334	**Person Responsible** RN4 **Monitor** DON	

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W 334	Continued From page 18 performed on the residents. The document does not clarify if the assessment was completed through a physical exam or resident document review. The Quarterly Nursing Review form directs staff to observe or review body systems when completing the assessment. Interview of the facility RN4 revealed that the nursing staff is expected to perform a direct physical examination for each Quarterly Nursing Review.	W 334		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation the facility failed to keep all drugs and biologicals locked except when being prepared for administration for 9 of 13 expanded sample residents (Resident #36, 37, 38, 39, 40, 42, 44, 47, & 48) during drug administration. Failure to lock the medication cart during drug pass placed residents at risk of harm due to the accessibility of unsecured drugs. Findings include: Observation of morning drug administration at Devenish on 02/06/13 revealed that after preparing the drugs for administration the nurse walked into a separate room to administer the drugs, leaving the medication cart unlocked and unsupervised on 9 separate occasions.	W 382	**W382 Drug Storage and Recordkeeping** Nurse will be retrained regarding locking the medication cart prior to leaving the medication cart to administer medication to client #48. Nurse will be retrained regarding locking the medication cart during each medication pass (occasion) when further than an arm's length away from the medication cart. All nurses will be trained in locking the medication cart anytime the nurse is more than an arm's length away. **Person Responsible** RN4 **Monitor** DON	Completed 3/22/13 Completed 3/31/13

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382	Continued From page 19 During the same drug administration process the nurse asked house manager to watch the unlocked medication cart as she exited the area to provide drugs to Resident #48.	W 382		
455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation during drug pass and environmental rounds, the facility failed to ensure an active program to maintain good hygiene practices for 9 of 81 expanded sample residents (Resident #38, 39, 41, 42, 43, 44, 46, 47, & 49). Failure to wash/sanitize hands between residents drug passes and failure to label/separate personal razors placed residents at risk of being exposed to a communicable disease. Findings include: Observation of resident bathrooms in [redacted] House on 02/05/13 revealed residents electric razors were placed on top of each other in a plastic box that also contained hair brushes and were not labeled with resident names for Resident #38, 39, 41, 42, 43, 44, 46, 47,& 49. Staff reported no system was in place to label or sanitize razors when they come in contact with other razors and/or grooming products. Interview of staff on 02/07/13 confirmed staff that is unfamiliar with the residents would be unable to identify the correct razor for the correct resident when razors are unlabeled.	W 455	**W455 – Infection Control** Residents #38, 39, 41,42, 43, 44, 46, 47, & 49 will have their personal grooming items individually labeled and stored.	Completed 2/11/13
			All PAT A residents' personal grooming items will be individually labeled and stored. New items purchased will be labeled prior to use.	Completed 3/11/13
			ACM's will check monthly to ensure all personal grooming items are labeled and individually stored.	Ongoing
			Person Responsible ACM **Monitor** DDA2	
			Nurse will be retrained to wear gloves or wash/sanitize her hands between residents' #38,40,44 and 48 medication passes.	Completed 3/15/13
			All nurses to be in-serviced to wear gloves or wash/sanitize their hands between each client's medication administration.	Completed 4/5/13
			Person Responsible RN4 **Monitor** DON	

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W 455	Continued From page 20 Observation of a drug pass in [redacted] House on 02/06/13 revealed the nurse failed to wear gloves or use hand sanitizer between the drug administration for Resident #38, 40, 44 [twice], and 48.	W 455		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation on 02/05/13, the facility failed to serve food within 15 minutes of removal from a temperature control device to 1 of 12 sample residents (Resident #6) and 14 of 14 expanded sample residents (Resident #36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, & 49) at [redacted] Failure to serve food promptly resulted in residents being served cold food and creating a potential for foodborne illness. Findings include: Observation of [redacted] Home on 02/05/13 revealed several luncheon food items had been removed from the refrigerator and freezer, reheated in the microwave and oven and left standing for over 20 minutes before serving to residents. Staff were asked to take the temperature of 3 food items that had been served to residents: One family size bowl of spaghetti-112°, one family size bowl of spaghetti-100°, one bowl of French fries-80°. The USDA guidelines recommend food must be reheated to 165 degrees Fahrenheit or above and held above 140 degrees Fahrenheit until served, in order to destroy the bacteria that can cause food borne illness.	W 473	**W473 Meal Services** All food items reheated in the microwave or oven will maintain a temperature held above 140 degrees. PAT A staff will be trained on how to correctly use a thermometer to ensure appropriate temperature. **Person Responsible** ACM **Monitor** DDA2	Ongoing Completed 3/31/13

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

March 13, 2012

Neil Crowley, Superintendent
Rainier School PAT A
P O Box 600
Buckley, WA 98321

RE: Recertification Survey 2/6/2012 through 2/9/2012

Dear Mr. Crowley:

A recertification survey of Rainier School PAT A was completed on February 9, 2012. This survey found no requirements unmet. Based upon this survey, Rainier School PAT A is recertified as an Intermediate Care Facility for the Mentally Retarded June 1, 2012 through May 31, 2013.

If you have any questions, please contact me at (360) 725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

cc: Janet Adams, DDD

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 000	INITIAL COMMENTS This report is a result of the annual recertification survey conducted at Rainier School -A on 2/6/12, 2/7/12, 2/8/12, and 2/9/12. The survey was conducted by: Kathy Heinz Janette Buchanan Terry Patton Gerald Heilinger The surveyors are from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809 Rainier School - A is in compliance with 42 CFR Part 483 Subpart I, "Participation for Intermediate Care Facilities for the Mentally Retarded"	W 000		

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ir safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/ID Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

March 15, 2011
Certified Mail (7006 2760 0000 0104 2049)

Neil Crowley, Superintendent
Rainier School PAT A
PO Box 600
Ryan road
Buckley, WA 98321

RE: Recertification Survey 2/14/11 through 2/17/11

Dear Superintendent:

From 2/14/11 through 2/17/11ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a complaint investigation at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the complaint investigation is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 45 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, QA Administrator
ICF/MR Survey and Certification Program
Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

DSHS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at 360.725.2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/MR Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G050	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is a result of a Recertification Survey at Rainier School PAT A completed by Mark White, Kathy Heinz, George Rogers and Terry Patton from 2/14/11 through 2/17/11 from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98333 Phone #: (253) 476-7171 FAX: (253) 593-2809	W 000	Nurse in training was provided direction by the RN4 related to the Medication Administration Procedure and initialing the MAR after the medication is delivered. Completion Date 2/16/11	
W 341	483.460(c)(5)(ii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel in methods of infection control. This STANDARD is not met as evidenced by: Based on observations, review of written procedures and interviews, it was determined a nurse administering medications, when being trained by another nurse, failed to follow a facility policy to control and prevent communicable diseases and infections. Findings include: Observation on 2/15/2011 from 8:35 AM to 8:55 AM at [redacted] House revealed a trainee nurse, with the training nurse present, failed to wash or	W 341	Nurse Medication Pass Evaluation form to be updated to clearly identify MAR verification and documentation after client receives medication. **Person Responsible:** RN4 **Monitor:** Director of Nursing Completion Date 3/31/11 Training on the updated Nurse Medication Pass Evaluation Form to be completed. **Person Responsible:** RN4 **Monitor:** Director of Nursing Completion Date: 4/29/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 3/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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RAINIER SCHOOL PAT A	RYAN ROAD BUCKLEY, WA 98321

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W 341	Continued From page 1 sanitize his hands prior to administering medications to Expanded Sample Residents #13, #14, and #15. The trainee nurse also dropped a packaged medication to the floor, picked it up, removed the medication from the package, placed the medication in the pill cup, and administered the medication without washing or sanitizing his hands. The training nurse did not tell the trainee nurse to wash or sanitize his hands. Review on 2/16/2011 of the facility "Medication Administration Procedure" revealed medications must be administered "using clean technique" and the nurse must wash "soiled/contaminated" hands immediately. Interview on 2/16/2011 with the Registered Nurse 4 confirmed that facility policy requires a nurse administering medication to wash or sanitize their hands prior to administering medications and whenever their hands may be contaminated.	W 341	Nurse in training was provided direction by the RN4 related to facility policy regarding sanitizing hands. Completion Date 2/16/11 Nurse Medication Pass Evaluation form to be updated to clearly identify hand sanitizing procedures. **Person Responsible:** Director of Nursing. **Monitor:** PAT A Director Completion Date 3/31/11	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observations, review of written procedures and interviews, it was determined a nurse administering medications, when being trained by another nurse, failed to follow facility medication documentation requirements, which may cause a medication administration error. Findings include: Observation on 2/15/2011 from 8:35 AM to 8:55 AM at [redacted] House revealed a trainee nurse; with the training nurse present, compared the individual medications to the Medication Administration Record (MAR) when removing the individual medications from the medication cart.	W 365		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 365	Continued From page 2 Next, the trainee nurse initialed the MAR. Then the trainee nurse administered the medications. The trainee nurse administered medications to Expanded Sample Residents #13, #14, #15, and #16 in the same manner. Review on 2/16/2011 of the facility "Medication Administration Procedure" revealed medications must be checked against the MAR three times prior to medication administration. In addition, the Procedure requires that the medications must be administered prior to initialing the MAR, to prevent medication administration errors. Interview on 2/16/2011 with the Registered Nurse 4 confirmed that facility policy requires nurses administering medications check the medication against the MAR three times prior to administering medications and the MAR is to be initialed after, not before, the medication is administered to the Resident.	W 365		

Aging & Disability Services

ICF2

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

March 9, 2010

By Facsimile

Neil Crowley, Superintendent
Rainier School PAT A
P O Box 600
Buckley, WA 98321

RE: Recertification Survey 02/17/2010-02/23/2010

Dear Superintendent Crowley:

Included with this letter you will find the draft CMS 2567 Statement of Deficiencies (SoD) which resulted from a recertification survey completed on 02/23/2010.

Please be advised of your right to review this draft survey and submit any additional information to clarify or dispute the survey team's findings. Your response should be faxed to the ICF/MR Quality Assurance office and arrive no later than two working days after the date the draft was faxed to your facility.

In the event that there is not a dispute with the survey findings, or once any disagreements pertaining to the survey report have been resolved, the SoD will be considered final and the Plan of Correction (PoC) will be due within ten calendar days of receipt of the final SoD.

In order to meet the ten day timeline, you may write the PoC onto the faxed copy of the SoD for review by the ICF/MR survey team and fax it back to this office, signed and dated, to:

Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

After review of the PoC by ICF/MR team, the original SoD will then be mailed to your facility in order to add the acceptable PoC. A copy of the guidelines for an acceptable PoC is included with this fax.

Thank you for your attention to this matter.

Sincerely,

Tom Farrow, Field Manager
ICF/MR Survey and Certification Program

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W 000	INITIAL COMMENTS This report is a result of an annual recertification survey and Complaint Investigation # 10-01-00592 conducted at Rainier School from 2/17/10 and 2/23/10 completed by #21833, # 19886, #12564 and #12891 D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interview verification, it was determined the facility failed to provide Individuals with a home that was in good repair. The vinyl floor in the service hallway and the kitchen of Naches house had holes, cracks, or pieces missing. Failure to provide a home that was in good repair resulted in Individuals living in a home that looked unsightly and had potential health and safety concerns. Findings include:	W 104	Naches House has been assessed for repairs necessary regarding potential health and safety concerns with the flooring in the Kitchen and service hallway. Rainier School will proceed with the replacement of the kitchen and service hallway flooring for Naches House. Rainier School will work with the Office of Capital Programs to award a contract before May 2010 for flooring repairs or replacement in the kitchen and service hallway. The flooring contractor's work will be completed within six months of award of contract. If unforeseen circumstances require more extensive repairs and have the potential to delay the work, Rainier School will communicate this with the survey team. **Person responsible:** QA Manager **Monitor:** PAT A DDA2	Completed 3/16/10 Ongoing

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dir. | 4/19/10

ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that feguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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W 104	Continued From page 1 Observations from 2/17/10 through 2/23/10 revealed the vinyl floor covering in the service hallway and the kitchen of Naches house had holes, cracks, or pieces missing. Interview with the Attendant Counselor Manager for Naches House on 2/23/10 verified the floors were in disrepair.	W 104		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to thoroughly investigate an incident in which expanded sample Resident #13 was discovered to have multiple yellowish bruises on her right breast. Although there was no evidence to support the conclusion, the facility determined the injuries were self inflicted. Failure of the facility to conduct a thorough investigation prevents the facility from knowing if individual s are being abused. Findings Include: Review on 2/17/10 of a facility investigation revealed Resdident #13 was discovered to have several bruises on her right breast. The facility assumed the injuries were self inflicted. The facility investigation did not address the pattern of injuries. The facility investigation did not discover that the current tracking system of self injurious behavior does not distinguish what type of behavior was documented. The facility investigation did not discover that there were no interdisciplinary notes addressing self injurious behavior around the time of discovery. The facility investigation did not consider or review	W 154	PAT A will re-open the investigation (client #13) noted within this citation to address if there is a pattern and frequency of incidents of the same injury. Completed 3/26/10 The behavior tracking system of SIB for client #13 will be changed to better describe (body part) what type of SIB occurred. Completed 3/5/10 2010A Staff (related to this incident) will be re-trained regarding completing progress notes related to SIB. Completed 3/26/10 All alleged incidents of abuse or neglect will be thoroughly investigated as a major incident. All PAT A employees responsible for conducting incident investigations will receive instructions/training regarding thorough investigations. Completed 4/7/10 Behavior tracking systems of SIB will be reviewed for all PAT A clients. If SIB includes vulnerable body parts, the tracking system will be changed to reflect accordingly. Completed: 4/9/10	

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W 154	Continued From page 2 prior incidents in which Resident #13 was discovered with bruising on her breast. The facility investigation did not consider why staff who bathed her the night prior to the discovery did not see the bruising. Interview with administrative staff on 2/23/10 verified the investigation did not contain these elements.	W 154	PAT A Director will review all investigations ensuring that thorough investigations are occurring. Ongoing Person responsible: PAT A Director Monitor: Incident Coordinator	
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined seven of twelve sample Residents (#1, #3, #4, #8, #10, #11 and #12) did not have Active Treatment Schedules, current Active Treatment Schedules or Active Treatment Schedules that were individualized . Failure to have current Active Treatment Schedules resulted in direct care staff not having clear direction as to what activities Resident should or could participate in. Findings include: 1. Observation of Resident #12 on 2/17/10, 2/18/10 and 2/19/10 revealed he did not attend any Adult Training Program (ATP) activities. Review of Resident #12's Habilitation Record on 2/22/10 revealed the Active Treatment Schedule dated 2007 documented Resident #12 was supposed to attend ATP Sensory activities Mondays, Wednesdays and Fridays. Interview with Direct Care Staff on 2/19/10 revealed Resident #12 was not supposed to attend the	W 250	Active treatment schedules that outline the current active treatment program will be developed for Residents #1, #3, #4, #8, #10, #11, #12. These schedules will be readily available for review by relevant staff. Completed 3/19/10 All active treatment schedules will be reviewed annually (IHP month) or modified when major program changes occur (within IHP year) to ensure the outline for current active treatment programs is accurate and readily available for review. Ongoing Person Responsible AC Managers Monitor PAT A DDA2	

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W 250	Continued From page 3 ATP Sensory Room activities. Interview with Administrative Staff on 2/22/10 verified Resident #12 ' s Active Treatment Schedule was not current. 2. Review on 2/22/10 of Resident #3's Habilitation Record revealed the Active Treatment Schedule was not current and did not reflect what he was observed to be doing. Interview with administrative staff on 2/22/10 verified the Active Treatment Schedule was not current. 3. Review on 2/22/10 of Resident #1 and #4's Habilitation Record revealed the Active Treatment Schedule was not individualized for her. The Active Treatment Schedule was generic and could apply to any one due to the lack of specificity. Interview on 2/22/10 with administrative staff verified Active Treatment Schedule was generic and not individualized. 4. Review on 2/22/10 of Resident #8, #10 and #11's Habilitation Records revealed there were no Active Treatment Schedules. Interview with administrative staff on 2/23/10 verified there were no Active Treatment Schedules.	W 250		

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

- Rainier School PAT C SODs 2015 – 2010

Note: There is no SOD for 2015. This survey is upcoming.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

October 2, 2014
CERTIFIED MAIL (7008 1300 0000 7188 4955)

Alan McLaughlin, Interim Superintendent
Rainier School PAT C,
PO Box 600
Buckley, WA 98321

RE: Recertification Survey
9/15/2014 through 9/18/2014

Dear Mr. McLaughlin:

From 9/15/2014 through 9/18/2014 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Rainier School PAT C on 09/15/14 through 09/18/14. A sample of 11 residents was identified. The survey was conducted by: Janette Buchanan, R.N., B.S.N. Terry Patton, R.N., B.S.N. Christina Borchardt, R.N., B.S.N. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2405 Fax: (360) 725-2642	W 000		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.	W 127		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 127	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to reduce the probability of further injuries from unobserved falls for 1 of 11 sampled residents (Resident #7). This failure placed resident at risk of serious harm due to lack of interventions being initiated. Findings include. Observation on 09/17/14 Resident #7 ambulating into the dining room with fresh blood in his hair at the back of his head. Staff G was made aware of the injury and asked resident what had happened. Resident #7 stated that he had fallen while in the bathroom. Nursing arrived to assess resident and found him to have a laceration to the back of his head and set up an appointment for Resident #7 to go to the clinic to be seen that morning. Neuro checks were started at that time. Record review revealed Resident #7 has a diagnosis of [redacted] severe form of [redacted] and has had many falls related to this with one resulting in having sutures placed after lacerating his head in the bathroom. Resident #7 is able to get him up off the floor after he falls and does not always tell staff that he has fall. Record review revealed Resident #7 had 7 falls in June 2014; 1 fall in July 2014, 5 falls in August 2014 and 1 in September to date. Record review revealed no actions were taken by the facility following these falls which may prevent injuries from future falls. Falls were as follows: · 06/01/14 Team aware, to discuss 06/05/14 · 06/02/14 Plan to review falls 06/05/14 · 06/06/14 Fall resulting in injury, soft cast and wheelchair ordered · 06/06/14 Fall, possible seizure · 06/22/14 Fall, possible seizure · 06/22/14 Fall, suspect seizure, discussed	W 127		

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RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

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W 127	Continued From page 2 at past 90 day review, is difficult to redirect to remain seated · 06/30/14 Fall, suspect seizure · 07/22/14 Fall, continue to monitor · 08/04/14 Fall, Interdisciplinary.Team Monitoring · 08/09/14 Fall (observed), laceration to head requiring sutures, discuss falls and falls with injury at 90 day review in September · 08/20/14 Fall (observed), discuss fall at next 90 day review on 09/05/14 · 08/24/14 Fall (observed), pattern of falls with injury, possible seizure, discuss at 90 day review on 09/04/14 · 08/25/14 Fall (observed), Switched armchair as plan of correction at work site · 09/17/14 Fall, laceration to head Staff B acknowledged, when interviewed, interventions were not put into place prevent Resident #7 from receiving further injuries from the falls.	W 127		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to provide or obtain preventative and general care for 4 of 11 sampled residents (Resident #2, 3, 5, and 7). Failure to provide or obtain preventative and general care placed residents at risk of medical issues which could lead to deterioration in their overall health. Findings include: All observations, record reviews and interviews	W 322		

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	50G047	A. BUILDING _____ B. WING _____	09/18/2014

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W 322	Continued From page 3 were conducted at the facility between 09/15/14 and 09/18/14. Annual Physical Examinations: Record reviews revealed Annual Physical Examinations by a Physician had not been done annually for Resident #2, 3, or 5. The most recent Annual Physical Examinations by a Physician were: • Resident #2 - last completed 09/28/12 • Resident #3 - last completed 05/29/13 • Resident #5 - last completed 05/24/13 Staff A acknowledged the Physical Examinations for Residents #2, 3, and 5 were more than a year old.	W 322		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 11 sampled residents (Resident #3 and 7) received annual, or as recommended, audiology examinations. Failure to provide a timely audiology exam placed residents at risk of unidentified changes in hearing and/or medical issues which could lead to deterioration in their overall health. Findings include: All observations, record reviews and interviews were conducted at the facility between 09/15/14 and 09/18/14. Record reviews revealed Resident #3 last had an audiology examination 08/13/09 with directions to return in 5 years for recheck. Resident #7 had an audiology examination 03/19/09 with directions	W 323		

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W 323	Continued From page 4 to return in 3 years for recheck. No follow up audiology examinations have occurred for Resident #3 or Resident #7. Interview with Staff A revealed that the facility had lost their audiologist several years prior and had just recently contracted with an audiologist to examine residents. Staff A stated that residents are prioritized to be tested by an audiologist based on which resident appears to have the greatest need.	W 323		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the times of evacuation drills varied during for 6 of 7 houses (1020, 1030, 1040, 1050, 2005, and 2014) during the past year. Failure to ensure evacuation drills were conducted under various and realistic conditions placed residents at risk of harm should an emergency occur that necessitates evacuation. Findings include: All record reviews were conducted at the facility between 09/15/14 and 09/18/14. Review of evacuation logs from 09/01/13 through 08/31/14 revealed many evacuation drills on each shift were conducted at or near the same time. 1020QC: All four Evacuation Drills conducted on day shift were between 7:00 AM and 9:45 PM. All four evening shift drills were conducted between 3:45 PM to 4:00 PM. 1030QC: All four Evacuation Drills conducted on night shift	W 441		

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W 441	Continued From page 5 were between 10:17 PM and 10:20 PM. 1040QC: Two of four Evacuation Drills conducted on evening shift were conducted at 2:50 PM and the other two Evacuation Drills were both conducted at 5:37 PM exactly. 1050QC: Three of four Evacuation Drills on day shift were conducted between 12:13 PM and 12:50 PM. Two of four night shift drills were conducted at 10:30 PM and the other two drills at 11:00 PM. 2005QC: The four Evacuation Drills on day shift were conducted between 9:45 AM and 1:45 PM; the four Evacuation Drills on evening shift occurred between 2:45 PM to 4:15 PM. Of the four Evacuation Drills on night shift, three were at 11:00 PM and one at 11:30 PM. 2015QC: The four Evacuation Drills conducted on night shift occurred between 11:58 PM and 1:00 AM.	W 441		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interviews, facility failed to observe infection control practices when staff failed to change gloves, or use other means to prevent cross contamination, between assisting residents during meal service for residents at House 1020. This failure placed residents at risk for illness due to exposure by cross contamination.	W 455		

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W 455	Continued From page 6 Findings include: Observation of Staff H helping House 1020 residents with lunch at 11:06 AM on 9/17/14 revealed he was wearing blue latex type gloves while helping residents. Staff H lifted Resident #12 from under her armpits while standing behind her to help her sit straighter in her chair at the lunch table. Staff H then walked to the other end of the table and picked up three unwrapped hotdog type buns, wearing the same gloves he wore when lifting Resident #12. Staff H then moved a tray of food, which included the buns he picked up, to a table at the side of the room. Staff H turned and picked up what appeared to be a napkin from the floor and put it in the garbage. Staff H, still wearing the same gloves, picked up a bun and went to the table where Resident #4 was sitting. Staff H cut up the bun for Resident #4. Staff H then removed his gloves, discarded them, used a hand sanitizer, and then put on clean gloves. Staff I revealed Staff H had been trained to avoid cross-contamination during meals.	W 455		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

August 7, 2013
CERTIFIED MAIL (7007 1490 0003 4201 9164)

Neil Crowley, Superintendent
Rainier School PAT C
PO Box 600
Buckley, Washington 98321

RE: Annual Recertification Survey
7/14/2013 through 7/18/2013

Dear Mr. Crowley:

From 7/14/2013 through 7/18/2013, ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

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W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey conducted at Rainier School - PAT C on 07/14/13, 07/15/13, 07/16/13, 07/17/13 and 07/18/13. A sample of 10 residents was selected from a census of 101. An expanded sample included 9 current residents. The survey was conducted by: Claudia Baetge Christina Borchardt Terry Patton Penelope Rarick The survey team is from: State of Washington Department of Social and Health Services Residential Care Services Administration ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure a well repaired and maintained environment which was free from safety hazards for 1 of 7 houses and provide toilet paper for 2 of 7 houses. This failure to provide a well repaired	W 104	W 104 GOVERNING BODY Gait/fence repairs were completed. Rusty nails were removed. Drain spout was replaced. PERSON RESPONSIBLE: ACM MONITOR: DDA2 09/13/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 and maintained environment placed residents at risk for injury. The lack of toilet paper prevented residents from maintaining good hygiene and personal dignity following toileting. Findings include: All observations and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated. Facility Exterior-Safety Hazards Observations at House 2025 revealed: 1. South side fence had 2 gated sections removed from posts that were leaning against main fence exposing protruding rusty screws and nails at hinges. 2. North side yard had gate with two rusty nails protruding from gates outer door edge. 3. Downspout on the corner of the house was broken and exposing sharp metal edges. Interview with 2025 facility staff revealed south side gated sections had been broken since moving into house in February 2013. Staff was not aware if a work order had been submitted for repair of broken fence gates. Facility Interior Observations at House 1030 revealed no toilet paper in bathrooms A13 and B13 on 07/14/13 at 3:40PM (for approximately 2 hours). Observations at House 2015 revealed no toilet paper in B side hallway bathroom on 07/14/13 at 3:30pm and 07/15/13 at 10:00am. Interview with House 2015 staff on 7/14/13 indicated residents use Attend Wipes in place of toilet paper. The Attend Wipes were located approximately 4 to 5 feet from toilet, out of reach of residents sitting on the toilet. However, interview with another House 2015 staff on	W 104	Rainier School staff will monitor their immediate work area for potential safety hazards and submit work requests to rectify deficiencies as they arise. PERSON RESPONSIBLE: ACM MONITOR: DDA2 On-going Rainier School staff will regularly monitor bathrooms on the house once per shift to ensure an adequate supply of toilet paper and other necessary hygiene products. PERSON RESPONSIBLE: ACM MONITOR DDA2 On-going ACMs will complete monthly environmental observation checklist to the PAT ensuring that these are done. PERSON RESPONSIBLE: ACM MONITOR: DDA1	

9/5/13

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W 104	Continued From page 2 07/15/13 acknowledged toilet paper should have been available to residents in B side bathroom, next to the toilet.	W 104		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to secure resident health care records for 1 of 1 sampled resident (Resident #4) and 9 of 9 expanded sample residents (Residents #11, # 12, #13, #14, #15, #16, #17, #18 and # 19). This failure created a potential for loss/misplacement of medical records and violation of residents ' rights to keep their medical information confidential. Findings include: On 07/17/13 observations on House [redacted] at 8:25AM and 11:30PM, revealed resident health care records were left unsecured on the counter of the medication administration area where they could have been observed by residents or visitors. The medication area is a common area in the house and is accessible by residents and visitors. There were no staff in the medication administration area during the observations. Nursing Orders and Treatment Record for Resident #4 and Resident #17 were face up on the counter of the medication administration area. Lying next to these documents was a manila file folder that contained the following health care	W 112	W 112 CLIENT RECORDS Rainier School will provide grounds-wide training to all nursing staff regarding current HIPPA requirements to securely maintain all sensitive and confidential client records. PERSON RESPONSIBLE: RN4 MONITOR: DIRECTOR OF NURSING 09/17/13 RN4 will complete weekly observations To maintain compliance of HIPAA regulations. PERSON RESPONSIBLE: RN4 MONITOR: DDA2 09/17/13	

AM
9/5/13

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W 112	Continued From page 3 records for residents who lived in House [1] Resident #4: Dental Assessment, dated 07/9/13 UA Request, dated 06/06/13 Resident #11: ER Visit Summary, dated 06/30/13 Lab Report, dated 07/01/13 Resident #12: Podiatry Report Resident #13: Annual Physical, dated 06/20/13 Resident #14: Specimen Report, dated 07/01/13 Resident #15: Routine Medical Re-Evaluation, dated 07/01/13 Resident #16: Optometry Report, dated 06/17/13 Specimen Report, dated 07/02/13 ER Report, dated 07/02/13 Resident #17: Dental Annual Assessment, dated 07/09/13 Resident #18: Annual Physical, dated 06/27/13 An Annual Physical, dated 05/31/13, for Resident #19 was also found in the manila file folder in the medication administration room of House [1] Resident #19 resides in House [1] Interview with the facility RN4 acknowledged all health care records should be secured and kept	W 112		

AM
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W 112	Continued From page 4 confidential by placing records in a locked drawer, cabinet or filing them in the resident ' s medical chart.	W 112		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to offer residents of three houses (House 1030, 2005 and 2015) a choice of food options during three dinner meals and two lunch meals. This failure resulted in residents not being allowed to exercise choice and self-management during meals. Findings include: Observation of House 1030 dinner on 07/14/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 1030 staff revealed they did not prepare or offer a food alternative to residents, but could provide peanut butter sandwiches if residents asked for an alternative to the food being served. Observation of House 2015 dinner on 07/14/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 2015 staff revealed that the alternative food choice was ravioli. The can of ravioli was not opened, nor offered to the residents.	W 247	W 247 INDIVIDUAL PROGRAM PLAN Rainier School will develop a grounds-wide procedure for meal preparation and serving responsibilities, which will include specific instructions on how to provide meal choices to the residents. PERSON RESPONSIBLE: DDA2 MONITOR: ASSISTANT SUPERINTENDENT 09/13/13 ACM's will complete two monthly meal time observations that monitor the procedure PERSON RESPONSIBLE: ACM MONITOR: DDA2 09/17/13	

9/5/13

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W 247	Continued From page 5 Observation of House 2005 lunch on 7/15/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 2005 staff revealed they did not prepare or offer a food alternative since they knew the meal provided by the main kitchen was a favorite of the residents. Observation of House 2005 and 1030 dinner on 07/16/13 revealed staff did not offer an alternative to the food items that came from the main facility kitchen. During interviews, staff on House 2005 revealed they did not have time to prepare an alternative food item and they were unable to provide food choices to the residents.	W 247		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an Annual Health Care Assessment was completed for 1 of 10 sampled residents (Resident #4). Failure to have an Annual Health Care Assessment placed resident at risk of unidentified medical issues and further deterioration of Resident #4 ' s health. Findings Include: All record reviews and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated. Record review reveals Resident #4 has a profound intellectual disability, [redacted]	W 322	W 322 PHYSICIAN SERVICES Rainier School will consolidate physician services into a centralized location in order to help ensure adequate physician coverage and timely assessments of resident needs. Resident 4 will have his annual physical completed Develop tracking sheet for use at the clinic in excel For clinic nurses and doctors to use when completing an AHCA PERSON RESPONSIBLE: CLINICAL DIRECTOR MONITOR: QA DIRECTOR	09/13/13

HM
9/5/13

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W 322	Continued From page 6 [redacted] intermittent pain), mild bilateral cataracts. Record Review revealed Resident #4 ' s last Annual Health Care Assessment was completed on 04/06/2012. Interviews revealed Resident #4 was inadvertently missed when scheduling Annual Health Care Assessments for his house.	W 322		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow the nursing care plan and report abnormal glucose values to the physician for 1 of 1 sampled residents (Resident #4), who is diabetic. Failure to follow the nursing order placed resident at risk of having blood glucose related complications and further deterioration of Resident #4 ' s health. Findings include: All record reviews and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated.	W 339	W 339 NURSING SERVICES All Registered Nurses (RN) will receive training on updating nursing care plans and nursing orders on their assigned caseload based on current resident need. RN4 will review at QA IDT quarterly review Sampled clients PERSON RESPONSIBLE: RN4 MONITOR: DIRECTOR OF NURSING	

KM
9/5/13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 7 Review of Resident #4 ' s Nursing Care Plan revealed the Nursing Problem/Diagnosis - Diabetes-Hyperglycemia. Review of Resident #4 ' s Nursing Order and Treatment Record (March, April, May, June and July 2013) reveals the order to report blood sugar <50 and >250 to MD or PAC. Review of Resident #4 ' s daily Diabetes Mellitus Blood Glucose and Insulin Monitoring form revealed the following glucose values: 03/23/13 - 41; 03/28/13 - 256; 4/08/13 - 347; 07/6/13 - 258; 07/11/13 - 325. Record review revealed staff failed to notify the doctor when the values were outside of the medical perimeters outlined in the nursing orders. During interviews, nursing staff acknowledged the failure to follow the nursing care plan orders.	W 339	All Licensed Practical Nurses (LPN) will receive training on implementing all nursing orders on their assigned caseload. RN4 will complete weekly observations for compliance. PERSON RESPONSIBLE: RN4 MONITOR: DIRECTOR OF NURSING 09/17/13	
W 455	483.470(i)(1) INFECTION CONTROL. There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to observe infection control practices. Resident hygiene items, food service, dishes/flatware handling and facility laundry were done in a manner which will cause cross-contamination. These failures placed residents at risk of illness due to communicable diseases. Findings include:	W 455	W 455 INFECTION CONTROL All AC staff will receive continuing and on-going training on appropriate infection control procedures, to include proper maintenance of personal hygiene equipment/products and the proper use of gloves and other personal protective equipment in the prevention of cross-contamination. Infection Control will submit quarterly Review of infection control issues noted on each house	

9/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 8 All observations and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated. At House 2005 4 of 8 razors and 2 hairbrushes were co-mingled in a drawer in bathroom A13. The bottom of the drawer was covered in loose facial hair from the razors. At Houses 1030 and 2005 staff wore gloves when using hand-over-hand technique to assist residents with serving their food. Staff then continued to wear the same gloves when they handled hamburger buns, wiped residents ' mouths, removed spilled food from a resident ' s laps, touched clean and dirty plates, touched clean and dirty utensils. At House 2035 Staff A was observed touching a resident ' s shoulder, a resident ' s hand, countertops, cabinets and her hair while wearing gloves. Then, while wearing the same gloves, the staff removed clean dishes and utensils from the dishwasher and touched areas where food would come in contact with the dishes and utensils. On 07/18/13 staff working in the facility laundry were observed loading soiled linen and clothing into front loading washing machines. When loading the washing machines the soiled items and/or soiled gloves worn by staff came in contact with the inside of the washing machine door, the seal around the washing machine door, the door handle, the front of the washing machine and the control knobs. Staff did not use any disinfectant to sanitize any areas of the washing machines which may have been contaminated	W 455	All laundry staff will receive training on infection control techniques to include avoidance of cross-contamination and disinfection of all appropriate surfaces. To the program area director PERSON RESPONSIBLE: Infection Control MONITOR: ACM /DDA2 09/17/13 Infection control nurse will complete quarterly observations of the laundry area to ensure techniques of cross contamination are being used and submit to all program areas. PERSON RESPONSIBLE: LAUNDRY SUPERVISOR/INFECTION CONTROL NURSE MONITOR: DDA2 08/20/13	

9/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 455	Continued From page 9 when loading soiled clothing and linens. When removed from the washing machines, the clean clothing contacted the contaminated door rim and front of the washer. Staff wearing clean gloves while removing the clean linen and clothing, touched the contaminated areas of the washing machine. On 07/18/13, Staff B stated the laundry staff believed when the clothes washer was turned on it cleaned the rim of the machine of contaminates. Staff were unaware of the need to disinfect the contaminated door rim, the door seal and outside surface of the clothes washer.	W 455		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to maintain the appropriate food temperature on House 1030, 2005, and 2015. This failure to serve food at the appropriate temperatures resulted in residents being served food at inappropriate temperatures creating potential for foodborne illness. This failure also denied residents their dignity in being served meals at appropriate temperatures. Findings include: Observation of 2015 house dinner meal on 07/14/13, revealed food was served at the following temperatures: beef patty 92°, tater tots 91° and vegetables 96°. In addition, two special diet order meals in individual containers were served at the following temperature. Meal 1: beef patty 75°, tater tots 80°, and vegetables 80°. Meal 2: beef patty 80°.	W 473		

AM 9/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 473	Continued From page 10 Observation of 1030 house dinner meal on 07/14/13, revealed milk was served at 54.1°. Observation of 2005 house lunch and dinner meal on 07/16/13, revealed the food was served at the following temperatures: cooked carrots 120°, coleslaw 58°, beef patty 120° and milk 60°. Interviews with staff on House 1030 and 2005 revealed staff were unaware of food temperature guidelines. When asked, staff were unable to report what holding temperatures should be for hot and cooled food items. Staff from both houses reported that it was a challenge to keep food cool during the hot weather. Staff also had difficulty understanding the process for correctly taking food temperatures. The USDA guidelines recommend food must be reheated to 165° Fahrenheit or above and held above 140° Fahrenheit unit served, in order to destroy bacteria that can cause food borne illness. Cold food items should be held and served at 45° or cooler.	W 473	W 473 MEAL SERVICES Rainier School will develop a grounds-wide procedure for meal preparation and serving responsibilities that will detail how staff are to monitor and maintain optimum food temperatures for both hot and cold foods. PERSON RESPONSIBLE: DDA2 MONITOR: ASSISTANT SUPERINTENDENT Rainier School will order appropriate equipment to ensure proper monitoring and maintaining of optimum food temperatures (i.e., thermometers, hot and cold serving containers). PERSON RESPONSIBLE: DDA2 MONITOR: ASSISTANT SUPERINTENDENT 09/30/13 ACM's will complete two monthly meal time observations that monitor the procedure PERSON RESPONSIBLE: ACM MONITOR: DDA2	

9/5/13

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600
July 31, 2012
CERTIFIED MAIL (7008 1300 0000 7157 1800)

Neil Crowley, Superintendent
Rainier School PAT C
PO Box 600
Buckley WA 98321

RE: Annual Recertification Survey
6/19/2012 through 6/21/2012

Dear Mr. Crowley:

From 6/19/2012 through 6/21/2012 ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Rainier PAT C on June 19-21, 2012. A sample of 10 residents was selected from a census of 100 residents in facility. The survey was conducted by: Janette Buchanan R.N., B.S.N. Terry Patton R.N., B.S.N. Christina Borchard R.N., B.S.N. The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: 360-725-2419 Fax: 360-725-2642	W 000		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to conduct all required quarterly fire drills. This placed 32 of 32 residents at risk of inadequate response to fire or other emergency evacuations.	W 440	W 440 Evacuation Drills PAT C Attendant Counselor Managers will be in-serviced on the requirement of monthly fire drills and rotating shifts completed by their staff. PERSON RESPONSIBLE: DDA1 MONITOR: DDA2	08/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	08/21/2012

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W 440	Continued From page 1 Findings include: The facility failed to conduct any night shift fire drill for the fourth quarter of 2011 for the cottage with address 1010 QC. The facility failed to conduct any night shift fire drill for the first quarter of 2012 for the cottage with address 1040 QC.	W 440		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to investigate why two quarterly fire drills were not conducted. Failure to investigate why the fire drills did not occur placed residents at risk of injury or death in the event of a fire or other evacuation emergency. Findings include: The facility failed to conduct any night shift fire drills for the fourth quarter of 2011 for the cottage with address 1010 QC. The facility failed to conduct any night shift fire drill for the first quarter of 2012 for the cottage with address 1040 QC. The DDA2 was aware these quarterly fir drills were not conducted when the fire drills were audited beginning of the next month and had staff for these cottages retrained.	W 448	W448 Evacuation Drills DDA2 will implement a monthly QA of evacuation drills PERSON RESPONSIBLE: DDA2 MONITOR: Supt	08/03/2012

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

March 15, 2011
CERTIFIED MAIL 7007 1490 0003 4205 6961

Neil Crowley, Superintendent
Rainier School PAT C
P O Box 600
Buckley, WA 98321

RE: Annual Recertification
6/27/2011 through 6/30/2011

Dear Mr. Crowley:

From 6/27/2011 through 6/30/2011 ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

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W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey conducted at Rainier School - PAT C on 06/27/11, 06/28/11, 06/29/11, and 06/30/11. A sample of 10 residents was selected from a census of 100. The Expanded Sample included 2 additional current residents. The survey was conducted by: Gerald Heilinger Kathy Heinz Terry Patton Mark White	W 000	RECEIVED DSHS/ADSA OCT 03 2011 Residential Care Services Certified Residential Programs	
	The survey team is from: Department of Social and Health Services Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809			
W 135	483.420(a)(10) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility did not allow Residents at [redacted] a phone	W 135		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

9/29/11

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 135	Continued From page 1 which maintained privacy and no distractions. Only the phone at the staff desk was available for Resident use. Findings include: Observation on 6/29/11 revealed Resident #12 at [redacted] did not have access to a phone where he could talk privately. Resident #12 was talking to his aunt on a phone located at the staff desk. The staff desk is located in the middle of the living area of the house. Resident #12 was trying to make arrangements to visit with his aunt. There were several staff and residents congregated in the area while Resident #12 was trying to talk on the phone. Staff were talking amongst themselves and made no attempt to assist the Resident to be able to talk to his aunt in private. Staff made no attempt to lower their voices so Resident #12 could hear his aunt. A Resident was walking around the living area and banging on the walls. Staff made no attempt to quiet the Resident so Resident #12 could hear his aunt. Resident #12 was observed covering one ear with his hand and repeatedly stating to his aunt that he could not hear. Interviews with Resident #12 on 6/29/11 and staff verified the only phone available for Residents to use was the one located at the staff desk. Resident #12 stated he wished he could talk on the phone in his room where it was quiet.	W 135	W 135 Protection of Clients Rights Facility will ensure that a second non-desk phone is available for residents to use for private phone calls. PERSON RESPONSIBLE: Attendant Counselor Managers MONITOR: Area Director Completion:08/10/11 W 135 Protection of Clients Rights Train all staff on SOP 3.03 Client Rights Resident 12 will have access to a cordless phone. for private phone calls per SOP 3.03 Client Rights. "Right to the opportunity for personal privacy; right to privacy during treatment of personal care needs, and conferences;" PERSON RESPONSIBLE: Attendant Counselor Managers MONITOR: Area Director Completion: 09/10/2011	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on Observations, interviews and record reviews, it was determined staff at 1050 Quinault	W 247		

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W 247	Continued From page 2 Court (QC), without management staffs' knowledge, locked snacks in a closet and only they had keys to unlock it. So, when Resident #11 wanted a snack he had to ask staff to unlock the closet, even though he was capable of getting the snack himself if the cabinet had not been locked. At the dinner and lunch meal on 1040 QC staff dished up food that had been prepared at the main kitchen and gave it to Resident #7 and 10 other non-sample Residents without asking them what they wanted to eat, even though the facility had trained staff to encourage and offer choices during meals. Staff did not give Residents the opportunity to help prepare their meals of their own choosing. Failure to allow Residents to have access to snacks and determine what they want to eat for their meals prevents Residents from controlling when and what to eat. Findings Include: 1. Observation on 6/28/11 and 6/29/11at house [redacted] revealed Resident #11 was eating cookies and drinking chocolate milk for his morning snack. When Resident #11 was finished, he asked for more cookies. Staff went to a closet marked " dirty laundry " and opened the locked door using a key. Staff got out more cookies and relocked the door. Staff then gave Resident #11 the cookies. Observation of the closet revealed it contained cookies, chocolate syrup, jam, cereal and other snack and condiments. None of these items were observed to be in the kitchen cupboards. Review of Resident #11's on 6/29/11 file, revealed there were no documentation that indicated Resident #11 should not have free access to snack and condiments or that snack and condiments needed to be in a locked closet. An interview with	W 247	W 247 Individual Program Plan The individual program plan will include opportunities for client choice and self-management. The locked cabinet on 1050 house that contained client snacks will be unlocked. Clients that want their personal snacks secured from other clients will have a plan developed by the IDT that includes appropriate access for the client. Client 11 will have full access to snacks. PERSON RESPONSIBLE: Attendant Counselor Manager/HPA MONITOR: Area Director Completion: 09/22/11 W 247 Individual Program Plan All staff will be re-trained on offering meal choices appropriately using newly developed "Why Is Choice Making Important" curriculum. PERSON RESPONSIBLE: Attendant Counselor Manager MONITOR: Area Director Completion: 09/22/11 Resident 7 and 10 will be presented meals using choice making curriculum and dinning scripts 1040 staff will be trained on Resident 7's dining script PERSON RESPONSIBLE: Attendant Counselor Manager MONITOR: Area Director Completion: 09/22/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 3 the Attendant Counselor Manager on 6/30/11 revealed he was not aware the " snack " closet was being locked by the staff. 2. Observations of sample Resident #7 at [redacted] on 6/28/11 during dinner and on 6/29/11 during lunch revealed staff placed food from the kitchen cart into serving bowls and placed the serving bowls onto a rolling cart. The staff then rolled the cart into the dining room and served all of the Residents. Resident #7 and the 10 other Residents were not encouraged to assist staff to place the food into serving bowls or putting the bowls onto the rolling cart. The only food on the cart was what came from the main kitchen and there were no other food items from which Resident #7 or other Residents could choose in lieu of what was offered through the facility's main kitchen. One staff did state, to Resident #7 and two other Residents at the table, that they could have other "choices". However, there were no other choices readily available and neither Resident #7 nor the other Residents responded to the comment and did not show any sign they understood they could have food other than what was on their plates in front of them. Observation of 10 additional Residents who were in the dining room during the same meals revealed there were no other types of food out (where Residents could see it) from which they could make a choice from. Review on 6/29/11of Resident #7's Comprehensive Functional Assessment dated 10/19/10 revealed Resident #7 indicates choices by pointing to or reaching for the desired items. An interview with the Attendant Counselor Manager (ACM) on 6/29/11 confirmed that the bulk of the Residents who live	W 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 247	Continued From page 4 at the house and in particular Resident #7 make choices visually (need to have the item/s in front of them) as they do not have the cognitive ability to understand choices they cannot see or smell. She also stated all the direct care staff had been trained to offer Residents choices and that the choices should be readily available so the Residents could see them.	W 247		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		
	This STANDARD is not met as evidenced by: Based on observations, interview and record review, it was determined the facility failed to have a transition plan whereby, they could assure that an outgoing Attendant Counselor Manager (ACM) provided the necessary documentation that the monthly fire drills had been conducted per their standard Operating Procedure, for 1 of 7 houses (1040 Quinault Court), to the incoming ACM. Failure to develop a transition plan resulted in the facility not knowing if the required fire drills had been conducted. Findings include: Review on 6/27/11 of the annual fire drill reports revealed that 1040 QC did not have documentation that a fire drill was conducted during the day shift during the quarter of January, February and March of 2011. Interview with the ACM on 6/29/11 verified no documentation verifying the drill could be found. She further stated that she had recently taken over the responsibility of managing 1040 QC and that the outgoing ACM had retired and that the fire drill report could not be located. Therefore, she could		W 440 Evacuation Drills Area Director will establish a checklist to ensure that fire drills are received by Administration per SOP. RSC receives drill, ensures appropriate documents are attached, sends to area director for review and signature, once signed sends copy to safety and PAT C Secretary for filing in master file. PERSON REPONSBILE: Area Director MONITOR: Asst Superintendent Completion: 09/10/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 440	Continued From page 5 not tell if the fire drill had occurred.	W 440		

Rainier School
Standard Operating Procedures

3.03 Client Rights/Grievance Procedure

Effective: 7-1-05

Superintendent

1.0 INTRODUCTION/PURPOSE:

This procedure recognizes clients' rights, a process for modifying the rights of clients, and grievance procedures and advocacy.

2.0 DEFINITION:

Civil Rights - Rights belonging to a person by virtue of his or her status as a citizen or as a member of civil society (based in law).

Human Rights - Rights belonging to a person by virtue of his or her humanity.

Protection and Advocacy System - An agency developed as a result of state and federal legislation to protect the legal and human rights of individuals with developmental disabilities, such as Washington Protection and Advocacy System (WPAS).

3.0 GUIDELINES:

Clients of Rainier School have the same basic human and civil rights as any other citizen. As clients of a facility for the developmentally disabled which meets certain requirements established by the federal government, clients have additional very specific rights. Although the degree to which any of these rights will be exercised may vary in relation to each client's individual disability and required treatment, the right itself is never lost. Any law, rule, or procedure modifying or intruding upon these rights will be applied reasonably and with sufficient safeguards (hearings, notices; et. al) to ensure that the individual is dealt with fairly. In situations where it has been determined that a client is incapable of understanding his/her rights, the client's guardian is advised of these rights. Where no guardianship exists, an advocate may assist the client in the preservation and maintenance of the client's rights.

Clients' Rights

Right to be informed of clients' rights and responsibilities;

Right to exercise rights as a client of the facility, and as a citizen of the United States, including the right to vote, unless otherwise amended by court order;

Right of access to the courts; right to counsel, including the office of the Washington Protection & Advocacy System; and the right to obtain private legal representation;

Right to voice grievances and to recommend changes in procedure and services;

Right to participate in the development of the Individual Habilitation Plan identifying needs; in the design of programs that meet those needs; and to participate in the selection of alternatives to the program(s) he or she rejects;

Right to active treatment as specified by concerns addressed in the Individual Habilitation Plan;

Right to be transferred or discharged only for good cause of the client;

Right to medical treatment;

Right to be informed of medical condition and current developmental and behavioral status;

Right to be informed of any attendant risks of treatment;

Right to refuse or to withdraw consent during any medical or habilitative treatment; to refuse or to withdraw from research projects;

Right to be free from drugs and physical restraints; right to treatment to reduce dependency on drugs and physical restraints;

Right to the opportunity for personal privacy; right to privacy during treatment, care of personal needs, and conferences;

Right that all information contained in personal records will be kept confidential and discussed (only with those who have a need to know) in a confidential and private area.

Right to be free from any physical, verbal, sexual, or psychological abuse or punishment;

Right to adequate housing, food, and clothing;

Right to retain and use personal possessions and clothing; right to dress in one's own clothing each day;

Right to decline search of person or personal belongings or premises;

Right to communicate, associate, and meet privately with individuals of his or her choice;

Right to send and receive unopened mail, including mail that may appear to contain legal documents in which case the social worker will accompany the client to the Mail Room for in-person delivery, except that PAT A client mail will be delivered directly to the social worker who will assist the client;

Right of access to telephones with privacy for incoming and outgoing calls;

Right of opportunity to participate in social, religious, and community group activities;

Right for a husband and wife, if both reside at the facility, to share a room;

Right not to be compelled to perform services for the facility; right to be compensated at prevailing wages, and commensurate with abilities for any work performed for the facility;

Right to manage personal financial affairs and to be taught to do so to the extent of his or her capabilities; and

Right to personal sexual expression as defined by the IHP and legal status.

Informing/Reviewing of Client Rights

Informing clients, parents, and legal guardian(s) is the responsibility of the PAT social worker on at least the following occasions:

Every client, parent, and the client's legal guardian(s) will be informed of client's rights at the time of admission.

Every client, parent, and the client's legal guardian will be informed of client's rights during the annual development and review of the client's Individual Habilitation Plan (IHP).

A client nearing emancipation, either because of age or legal process, and any involved family members, will be advised to consider possible need for a legal guardian to be appointed to provide continuing protection of the client's rights.

Notification

A social worker's review of rights with a client includes assessment of the individual's ability to understand, and the explanation of rights is to be presented in a manner appropriate to the individual.

In those situations where there is no indication the client has the ability to understand his/her rights and the client has no legal guardian to represent him/her, action is to be initiated by the social worker toward appointment of a legal guardian.

All staff will actively promote the growth, development, and independence of the client. Staff will ensure clients' rights are protected/enforced.

Modification of Clients' Rights

Modification of clients' rights may be initiated as a part of the individual's IHP process and only when the purpose and outcome of the modification can be seen as a greater good than absence of the modification.

Any modification of clients' rights shall be subject to a formal review process as described.

Grievance Procedures

Each client, personally or through a representative (guardian, staff, family member, friend, or interested party), has the right to grieve client conditions, client rights, and client treatment issues. Each client has the right that a grieved issue will be thoroughly processed.

The social worker for each client who feels aggrieved will have the responsibility to process the grievance until resolution through the appropriate channels; and will respond to the client within one working day.

If the client, guardian, or concerned person is dissatisfied with the action taken to resolve the grievance, he/she will be referred to the PAT director who will respond within **three** working days to the grievant.

If the client, guardian, or concerned person continues to be dissatisfied with the action taken to resolve the grievance, he/she will be referred to the superintendent. The superintendent will respond within **five** working days.

Should there be no agreed resolution, the grievant will be referred to the Human Rights Committee (HRC) for appropriate review and resolution. The committee will respond to the grievant within one working day following the next regularly scheduled Human Rights Committee meeting.

If unable to reach resolution of the grievance with the Human Rights Committee action, the grievant may utilize legal counsel to seek judicial review.

Complete records of the grievance will be kept and filed with the superintendent.

Each client, personally, or through his or her representative, has unencumbered access to advocacy. Staff may not circumvent this access. Advocacy may be obtained through Washington Protection and Advocacy at 1-800-562-2702, Support Services(Formally the Association of Retarded Citizens) at (253) 383-2643, or People First at (360) 709-9704.

Clients, or their representatives, may choose to facilitate the grievance procedure either through the internal grievance procedure described above, through contacting an advocacy organization, or may choose to do both.

WPAS/DDD Access Agreement

In October 1996, DDD and WPAS signed an agreement outlining the access that federal law provides to WPAS. This agreement covers:

Access to records of residents;
Access to residents;
Access to investigate allegations of abuse and neglect;
Miscellaneous access for outreach programs and training sessions.

All Rainier School staff will read and follow guidelines outlined in the access agreement (see Appendix A - Guidelines to Access Agreement).

The social worker for each client at Rainier School will distribute information regarding WPAS to clients, guardians, and families and post printed information regarding WPAS as per agreement.

WHY IS CHIOCE MAKING IMPORTANT?

- Choice leads to personal satisfaction and quality of life.
- Choice prepares learners for independence.
- Choice increases motivation to learn.
- Choice may prevent problem behaviors.
- **Choice gives you power and control over your own life.**

There are many types of choice

Ranging from relatively simple ones such as what cereal to eat to complex ones that require individuals to weigh the benefits of multiple alternatives.

Choice is the act of selecting between 2 or more options. Choice results in 2 outcomes.

1. Expression of preference. Preference is what you like relative to other options.
2. Expression of control. Control is the ability to direct activities or the actions of others.

Preference and control are equally important outcomes if choice making is to be meaningful a person needs to be given opportunities to achieve both.

CHOICE RESPONSES

Providing opportunities for choice making is meaningless unless the individual knows how to communicate a response. Teaching choice making involves three goals:

1. Teach learners how to clearly communicate their selection to others.
2. Teach learners that their selection will result in a preferred outcome.
3. Gives learners even greater control by teaching more sophisticated choice making skills expanding choice opportunities.

Old favorites quickly become boring options without opportunities to experience new things. This is why even if you think you know what a person may choose they are still provided with the option to make a choice.

By definition choice meant the opportunity to make selections free from coercion.

Choice Options

e types of choices made available will influence the individual's selection, even the decision to choose at all. Options must be meaningful. They must be presented in a way that is understood and that results in outcomes that are important to the individual.

Implications for Presenting Choice Opportunities

The following implications apply to all choice making strategies.

1. Present choice opportunities within the context of rich, stimulating environments in which the individual has frequent opportunities to experience new materials, activities and events. The greater the experience the greater the options for choice making.
2. Present meaningful choice options that lead to preferred events and/or control. Options must be sufficiently motivating to invite a choice response.
3. Honor choice selections. Respond quickly, especially when teaching beginning choice making skills.
4. Keep choice making inviting. By definition choice means the opportunity to make selection free from coercion. Choice should never be used to force people to do something that they do not want to do.

Teaching Beginning Choice Making Skills

Candidates for instruction in beginning choice making skills are often described as passive learners often fail to initiate activities on their own or may appear as such. They seem totally dependent on teachers, caregivers or parents for telling them what to do next. When presented with a choice opportunity passive learners may appear apathetic. They do not respond with a choice selection or they make non meaningful selections, such as always choosing the option that is on the right regardless of what option is present.

Overview of Teaching Choice Making

The primary strategy for teaching beginning choice making skills is
(a) to prompt the learner to signal a choice made between likes options and
(b) to provide the selected item upon each choice selection.
Through repeated opportunities, the client will learn how to make independent choice selections.

More importantly clients will learn that they have the power to influence their environment and gain access to preferred events. The following strategies will be covered in depth in the following material.

Preparing for Choice Opportunities

You must preplan choice prior to making them available to the client. Doing this sets the stage for a positive response.

- Select choice options based on "learner likes" Select options from daily routine, items that can be presented in small portions and items that are real.
- Identify and define a choice response. Choose a response that the learner can voluntarily control, is easily preformed, is understood by others as a choice selection and can be physically prompted if necessary.
- Choose routine activities (to present choice pairs). Choose two or three routines, one for each choice. Choose routines where choice can be honored.
- Plan how to present choice opportunities in small portion strategy or turn taking style.
- Assure that choices offered can be honored.

Identify and Define a choice Response

While preparing for choice opportunities you will identify and define a choice response. The best response is one that

(a) the learner can voluntarily control (is not reflexive)
(b) is easily performed
(c) is readily recognizable to others as a choice selection and,
(d) can be physically prompted if needed.

Look for behaviors the client can already perform. Once identified define the response by describing exactly how the client will indicate their selection. The following is an example: When presented with two options, Jon will indicate his choice by touching one of the items.

By choosing routine daily activities you will increase the time offered to make the choices as well as the retention of the choice making skill process.

Teach Choice Making

1. Sample options. Provide an opportunity for the client to experience each option. Note approach/rejection response.
2. Offer Options. Place options before the client left/right.
3. Ask. "Do you want this or this?" or, "Which one do you want?"
4. Wait. 5 to 10 seconds for a choice response or adjust for typical response time of that client.
5. Respond immediately if an independent choice response occurs. (A) Give a choice, remove other options. (b) Praise.
6. Prompt the choice response if an independent response does not occur.
7. Repair. If the learner refuses an option; take options away and never force.
8. Repeat steps 2 to 7 for another choice opportunity. (a) Continue as long as the client appears receptive to another choice trial. (b) Vary the position of the options, left or right, on each trial.

Be aware that some beginning choice maker will make mistakes. If a client rejects an option after making an independent or prompted choice selection then repair the situation, never force a client to engage in an unwanted activity. Remember to keep choice making a positive experience.

Embedding choices across daily routines

1. Identify daily routines.
2. Identify the types of choice options. Between activities choice and within activity choices.
3. Select a choice format. Utilizing closed or open questions.
4. Present choice options throughout the day.
5. Modify the choices. Are the types of choice options appropriate? Is the number of choice opportunities appropriate?

Limited Benefits

I've tried presenting choices, but the client just doesn't seem interested. Is it possible that certain people just do not benefit form choice making?

No!! All people benefit from choice making. It is our responsibility to make choice making work. After being denied opportunities for choice making, it may take time before some people with disabilities recognize the power of their choice selections. Be persistent. We encourage you as the staff to use, refine and adapt these procedures as you discover new choice making possibilities for the clients that you serve.

Example of how to offer choices to a reluctant person (Sam is a staff person. Joe lives where Sam works.)

TOOTH BRUSHING:

Sam: "Would you like to brush your teeth now?

Joe: no response is given.

Sam: "Okay, I'll check back with you in a few minutes to see if you are ready."

(A few minutes pass.)

Sam: "Okay, Would you like to brush teeth now?" Brings out a toothbrush to show Joe what he means.

Joe: no response

Sam: "It's time to go to work soon; you'll need to get this done before you leave today. When you are done you can continue what you are doing. Would you like to join me now or later?

Joe: Gets up and goes into the bathroom and brushes his teeth.

DINNER TIME:

Staff: "do you want to eat now?"

Joe: gets up and goes into the kitchen.

Staffer Sally: Offer 2 actual entrée's to Joe and ask "Joe, which one do you want to eat for dinner?"

Joe: makes a choice by reaching and taking the entrée he would like to eat.

Sally: offers choice of 2 drinks "do you want milk or Juice".

Joe: makes his choice reaching for the juice.

Sally: assures condiments are on the table, "do you want Catsup or mustard?"

Joe: points to both.

Sally: assists Joe to use both condiments.

THERE ARE DOZENS OF WAYS TO OFFER CHOICES

1. Do you want to do this now or later?
2. Are you ready to eat?
3. Do you want the apple or the orange?
4. Do you want a shower or a bath?
5. Which way do you want to go?
6. What do you want to do?
7. Can you tell me what you want?
8. Do you want to go to the media room or the gym? Show pictures
9. Do you want to brush your teeth in this bathroom or that one?
10. Do you want to get dressed first or eat first?
11. Where do you want to wait for the van?
12. Do you want to eat your snack in the kitchen or at the picnic table?
13. Do you want to take your meds now or in a few minutes?
14. Is it OK if I help you with your bath or would you rather have John help?
15. Are you ready to have dinner?
16. Dinner is ready when you are?
17. Do you want to go on an outing tonight?
18. Do you want to cut your nails or use a file?
19. Would you rather do something else?
20. Are you getting tired? You could go to bed?
21. Do you want ketchup?
22. Do you want mustard?
23. It's cold out. You might want to wear a coat?
24. Maybe if you wait to call your mom you would have a better chance of reaching her.
25. If you eat too much you might get sick. Do you want to save that for later?
26. If you go outside without shoes on you might hurt your feet. Do you want to put on shoes?
27. Point to the one you want?
28. If you don't like that you can look in the fridge for something else.
29. Which radio station do you want to listen to?
30. Do you want to find something else on the TV?
31. What restaurant do you want to go to? Look at pictures
32. Do you want dressing on your salad?
33. Do you want to wear the pink shirt with the blue jeans or green shirt with the brown pants?
34. Do you want to help me set up for dinner?
35. Would you like to go outside?
36. Your shirt is dirty. Would you like to change into a clean one?

CHOICE MAKING COMPETENCY REVIEW

Demonstrate how to offer choice of the following:

- **Taking a bath**

_____ Pass _____Retrain

- **If someone chooses to eat between meals**

_____ Pass _____Retrain

I have received training and have demonstrated competency

_____

sign and date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23
July 15, 2010
BY FACSIMILE

Neil Crowley, Superintendent
Rainier School P.A.T. C
P O Box 600
Buckley, WA 98321

RE: Recertification Survey 06/28/2010-07/02/2010

Dear Superintendent Crowley:

Included with this letter you will find the draft CMS 2567 Statement of Deficiencies (SOD) which resulted from a recertification survey completed on 07/02/2010.

Please be advised of your right to review this draft survey and submit any additional information to clarify or dispute the survey team's findings. Your response should be faxed to the ICF/MR Quality Assurance office and arrive no later than two working days after the date the draft was faxed to your facility.

In the event that there is not a dispute with the survey findings, or once any disagreements pertaining to the survey report have been resolved, the SOD will be considered final and the Plan of Correction (POC) will be due within ten calendar days of receipt of the final SOD.

In order to meet the ten day timeline, you may write the POC onto the faxed copy of the SOD for review by the ICF/MR survey team and fax it back to this office, signed and dated, to:

Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

After review of the POC by ICF/MR team, the original SOD will then be mailed to your facility in order to add the acceptable POC. A copy of the guidelines for an acceptable POC is included with this fax.

Thank you for your attention to this matter.

Sincerely,

Tom Farrow, Field Manager
ICF/MR Survey and Certification Program

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W 000	INITIAL COMMENTS This report is the result of a Recertification Survey conducted at Rainier School PAT C from 6/28/10 through 7/2/10 completed by Mark White, Kathy Heinz, Gerald Heilinger, George Rogers and Terry Patton from: D.S.H.S. Aging and Disabilities Services Administration ICF/MR Survey and Recertification Program 1949 South State Street Tacoma, WA 98405-2850 MS:N27-23 Office Phone: (253) 476-7171 FAX: (253) 593-2809	W 000		
25	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to protect the rights of Residents at House [redacted] and [redacted] when they locked the kitchen cupboards. The cupboard contained food for Residents. Residents did not have keys and had to rely on staff to get the food. Findings include: 1. Observation on 6/29/10 at house [redacted] revealed a direct care staff unlocked a kitchen	W 125	W 125 Protection of Client Rights Kitchen cupboards on house [redacted] and [redacted] were unlocked. PAT C Houses were checked for unauthorized locked cupboards [redacted] and [redacted] IDT's met and reviewed the need for client #9, #5 and #6 restricted access to food/snacks. There is currently no need for locked cupboards. PERSON RESPONSIBLE: IDT/QMRP MONITOR: DDA2	07/21/10

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Supt. 7-29-10

ncy statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 125	Continued From page 1 cupboard and removed cookies and granola bars. The staff offered the snacks to sample Resident #9. Review of Resident #9 ' s file revealed there was no indication the facility took the necessary steps to abridge her right to have access to food of her choice. Interview with a facility administrator on 7/1/10 verified the kitchen cupboards were locked and that that staff had to unlock the cupboard in order for Residents to gain access. 2. Observation on 7/1/10 at [redacted] revealed that 3 kitchen cupboards were locked. The locked cupboards contained snack food. Review on 7/1/10 of the Records for Sample Residents #5 and #6 revealed that neither Resident was on a Behavioral Support Program (BSP) which limited access to snacks. Neither resident had a consent and/or human rights committee approval for locking snacks away from them. Interview with a facility administrator on 7/1/10 verified the kitchen cupboards were locked and that staff had to unlock them in order for Residents to get food.	W 125	PAT C Staff will receive training on ensuring client rights are not violated and due process will occur when restrictions are indicated PERSON RESPONSIBLE: DDA2 MONITOR: DDA2 DDA1 will do quarterly environmental checks of living Units to ensure that client rights are protected and due Process is provided PERSON RESPONSIBLE: DDA1 MONITOR: DDA2	09/05/10 On-going
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to report 3 incidents of alleged neglect. The facility ' s failure to report allegations of neglect prevents the State	W 153	W 153 Staff Treatment of Clients Rainier School will continue to report Any allegations of neglect, mistreatment or abuse as well As injuries of unknown source to the administrator Or to other officials in accordance with State law Through established procedures. PERSON RESPONSIBLE: DDA/DDA2 MONITOR: ADMIN	On-going

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W 153	Continued From page 2 Agency (SA) from monitoring the facility's system for preventing abuse, neglect and mistreatment. Findings include: 1. Review on 6/28/10 of an Incident Report and Investigation dated 2/4/10 revealed Expanded Sample Resident #18 told staff she had swallowed 5 AA batteries. There was no evidence the facility reported this to the SA. Interview on 6/29/10 with a facility administrator verified the investigation was not reported to the SA. 2. Observation on 7/1/10 of expanded sample Resident #13 revealed he had a large yellow bruise on the side of his face and neck. Interview with staff revealed he had fallen while being assisted in the shower and suffered a fractured [redacted] Review on 7/1/10 of a facility Incident Report and Investigation dated 6/24/10 revealed Resident #13 had sustained a laceration which required sutures and fractured [redacted] as a result of a fall in the shower. There was no evidence the incident was reported to the SA. Interview with Administrative staff on 7/1/10 verified the incident was not reported to the SA. 3. Review on 6/28/10 of an Incident Report and Investigation dated 2/21/10 revealed Expanded Sample Resident #15 was prescribed thickened liquids by his physician. A day after the change was made Resident #15 was given and drank a glass of water that was not thickened. There was no evidence the incident was reported to the SA. Interview with a facility administrator on 7/1/10 verified the incident was not reported to the SA.	W 153	Rainier School will investigate procedures outlined in the Nursing Home Regulations (purple Book) to establish a decision Tree for the inclusion of medication errors that are deemed neglect PERSON RESPONSIBLE: DDA/DDA2 MONITOR: ADMIN	08/13/10
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

DEPARTMENT OF HEALTH AND HU[illegible] SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G047	A. BUILDING _____ B. WING _____	07/02/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT C	RYAN ROAD BUCKLEY, WA 98321

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W 154	Continued From page 3 The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to thoroughly investigate 6 allegations of neglect. In each case the facility missed key elements of the incident which prevented them from knowing exactly what happened. Without knowing what occurred in the incidents, the facility cannot make corrections which will keep Residents safe. Findings include: 1. Review on 6/28/10 of an Incident Report dated and Investigation 2/4/10 revealed Expanded Sample Resident #18 told staff she had swallowed 5 AA batteries. The investigation did not verify if this was true and did not describe any actions the facility took to determine if the batteries had indeed been swallowed. The facility did not determine if there were AA batteries in Resident #18 ' s possession, if there were batteries at the house, and did not describe if any measures were taken to insure Resident #18 was safe. Interview on 6/29/10 with a facility administrator verified the investigation was not thorough. 2. Review on 6/28/10 of an Incident Report and Investigation dated 2/6/10 revealed Expanded Sample Resident #17 was dispensed the wrong medication by the Pharmacy. The investigation didn ' t identify or interview the nurse who might have given the incorrect medication to determine whether they recognized the error or if they followed facility medication administration procedures. The facility investigation failed to	W 154	W 154 Staff Treatment of Clients Investigations cited will be re-opened and made thorough. PERSON RESPONSIBLE: Investigators MONITOR: DDA2 Investigators will be re-trained on completing thorough Investigations that include key elements which Detail to the facility what exactly occurred. PERSON RESPONSIBLE: Investigators MONITOR: DDA2 PAT C Director will review all investigations, ensuring That issues related to facility practices will Addressed as a critical elements of a complete and thorough Investigation PERSON REPONSBILE: DDA2 MONITOR: Asst Superintendent	08/05/10 08/13/10 On-going

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W 154	Continued From page 4 recognize a potential nurse administration error. Interview on 6/29/10 with a facility administrator verified the investigation was not thorough. 3. Review on 6/28/10 of an Incident Report and Investigation dated 5/17/10 revealed Expanded Sample Resident #17 received a double dose of his morning medications when two different nurses gave him medications. The investigation did not describe how the second nurse was able to give Resident #17 his medications without first looking at the MAR. Interview on 6/29/10 with a facility administrator verified the investigation was not thorough. 4. Review on 7/1/10 of a facility Incident Report and Investigation dated 6/24/10 revealed Expanded Sample Resident #13 fell while showering. Resident #13 sustained a laceration to the chin that required sutures. Two days later it was discovered his [redacted] was fractured. The facility investigation failed to determine if the staff assisting Resident #13 was trained prior to showering Resident #13 or if the current procedure used to shower him was safe. The investigation failed to determine if the shower area was safe for Residents to use. In addition, the investigation does not document why the only witness to the event was not interviewed. Interview with a facility administrator on 7/1/10 verified the investigation was not thorough. 5. Review on 10/10/09 of an Incident Report and Investigation dated 9/22/10 revealed Expanded Sample Resident # 23 found 30 pills in a medication cart while cleaning it. The investigation failed to identify is the medications were still in their packaged, who the medication belonged to or if Residents received their	W 154		

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W 154	Continued From page 5 prescribed medications. They also did not identify which nurse/s was responsible for dispensing the medication or how the medication ended up in the bottom of the medication cart. Interview on 5/10/10 with a facility administrator verified the investigation was not thorough. 6. Review on 6/28/10 of an Incident Report and Investigation dated 4/12/10 revealed Expanded Sample Resident #14 did not receive her 4:00 PM or 8:00 PM prescribed medications. The Investigation did not address that the 4:00 PM medications had not been given. Rather, it only noted that the 8:00 PM medications were missed. The Investigation also did not address the fact that the nurse had signed the MAR without giving the medications. Review of the MAR on 6/28/10 verified the nurse had initialed that the medications had been given and later crossed out the initials. Interview on 7/1/10 with a facility administrator verified the Investigation did not address the missed 4:00 PM medications and the fact the nurse had signed the MAR without administering the medications.	W 154		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to obtain consents from the Human Rights Committee prior to locking kitchen cupboards at	W 262	W262 Program Monitoring and Change Kitchen cupboards on house [redacted] and [redacted] were unlocked. PAT C Houses were checked for unauthorized locked cupboards [redacted] and [redacted] IDT's met and reviewed the need for client #9, #5 and #6 restricted access to food/snacks. There is currently no need for locked cupboards. PERSON RESPONSIBLE: IDT/QMRP MONITOR: DDA2	07/21/10

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W 262	Continued From page 6 House [1] and [1] The locked cupboards contained food for Residents. Residents did not have access to the food. Findings include: 1. Observation on 6/29/10at [1] revealed staff unlocked a kitchen cupboard and offered Sample Resident #9 a snack. Review on 7/1/10 of Resident #9 ' s file revealed the Human Rights Committee had not approved the restriction of locking the cupboard. Interview with a facility administrator on 7/1/10 verified the Human Rights Committee had not approved the restriction. 2. Observation on 7/1/10 revealed that the kitchen at [1] had three locked cupboards which contained snack foods. Review on 7/1/10 of Sample Residents #5 and #6 ' s file revealed the Human Rights Committee had not approved the restriction of locking the cupboards. Interview with a facility administrator on 7/1/10 verified the Human Rights Committee had not approved the restriction.	W 262	PAT C Staff will receive training on ensuring client rights are not violated and due process will occur when ' restrictions are indicated ' PERSON RESPONSIBLE: DDA2 MONITOR: DDA2 DDA1 will do quarterly environmental checks of living' Units to ensure that client rights are protected and due Process is provided. PERSON RESPONSIBLE: DDA1 MONITOR: DDA2	09/05/10 On-going
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to obtain guardian consent to lock kitchen cupboards at House [1] [1] The cupboards contained food for Residents. Findings include:	W 263	W263 Program Monitoring and Change Kitchen cupboards on house [1] and [1] Q.C. were unlocked. PAT C Houses were checked for unauthorized locked cupboards [1] and [1] IDT's met and reviewed the need for client #9, #5 and #6 restricted access to food/snacks. There is currently no need for locked cupboards. PERSON RESPONSIBLE: IDT/QMRP MONITOR: DDA2	07/21/10

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W 263	Continued From page 7 1. Observation on 6/29/10 at house [redacted] revealed a staff unlocked a kitchen cupboard and removed cookies and granola bars. The staff offered the snacks to sample Resident #9. Review of Resident #9 ' s file revealed there were no consents from the guardian approving the locking of cupboards. Interview with the administrative staff on 7/1/10 verified the kitchen cupboards were locked and that the facility had not obtained guardian approval 2. Observation on 7/1/10 revealed that the kitchen in House [redacted] had three locked cupboards which contained snack food. Review on 7/1/10 of the records for Survey Sample Residents #5 and #6 did not reveal consent for locking the cupboards. Interview on 7/1/10 with a facility administrator verified that a written consent restricting access to snack foods had not been obtained.	W 263	PAT C Staff will receive training on ensuring client rights are not violated and due process will occur when restrictions are indicated PERSON RESPONSIBLE: DDA2 MONITOR: DDA2 08/05/10 DDA1 will do quarterly environmental checks of living Units to ensure that client rights are protected and due Process is provided PERSON RESPONSIBLE: DDA1 MONITOR: DDA2 On-going	
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart: This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to incorporate a restriction to lock the kitchen cupboard into Sample Resident ' s #9 ' s Individual Habilitation Plan (IHP). The Resident had to rely on staff to get preferred snacks.	W 289	W 289 Mgmt of Inappropriate Client Behavior Kitchen cupboards on house [redacted] and [redacted] were unlocked. PAT C Houses were checked for unauthorized locked cupboards [redacted] and [redacted] IDT's met and reviewed the need for client #9, #5 and #6 restricted access to food/snacks. There is currently no need for locked cupboards. PERSON RESPONSIBLE: IDT/QMRP 07/21/10 MONITOR: DDA2	

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W 289	Continued From page 8 Findings Include: 1. Observation on 6/29/10 at [redacted] revealed a staff unlocked a kitchen cupboard and removed cookies and granola bars. Staff #1 offered the snacks to sample Resident #9. Review of Resident #9 ' s file revealed the restriction was not addressed in the Individual Habilitation Plan (IHP). Interview with administrative staff on 7/1/10 verified the kitchen cupboards were locked and the restriction was not part of her IHP. 2. Observation on 7/1/10 at [redacted] revealed the kitchen had three locked cupboards which contained snack food. Review on 7/1/10 of the records for Residents #5 and #6 revealed the restrictions were not addressed in the IHPs. Interview on 7/1/10 with a facility administrator verified the kitchen cupboards were locked and the restrictions were not part of their IHPs.	W 289	PAT C Staff will receive training on ensuring client rights are not violated and due process will occur when restrictions are indicated PERSON RESPONSIBLE: DDA2 MONITOR: DDA2 DDA1 will do quarterly environmental checks of living Units to ensure that client rights are protected and due Process is provided PERSON RESPONSIBLE: DDA1 MONITOR: DDA2	08/05/10 On-going
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review it was determined the facility failed to insure medications were adminstered per the Physician's orders. Finidngs include: 1. Review on 6/28/10 of an Incident Report and Investigation dated 5/17/10 revealed Expanded Sample Resident #17 was given his morning medications twice in one day. 2. Review on 6/28/10 of an Incident Report and	W 368	W 368 Drug Administration Rainier School will update Medication Administration Procedure to reflect needed changes. PERSON RESPONSIBLE: Director Of Nursing Services MONITOR: ADMIN Rainier School will train all nursing staff on newly updated Medication Administration Procedures PERSON RESPONSIBLE: RN4's MONITOR: Director of Nursing Services	09/03/2010 09/21/10

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W 368	Continued From page 9 Investigation dated 4/25/10 revealed Expanded Sample Resident #19 was given pain medication at a dose higher than had been prescribed for him. 3. Review on 6/28/10 of a facility Incident Report and Investigation dated 1/9/10 revealed Expanded Sample Resident #13 received expanded sample Resident #12 ' s medication when the nurse failed to follow the facility medication administration protocol. 4. Review on 6/28/10 of an Incident Report and Investigation dated 4/7/08 revealed Expanded Sample Resident #14 did not receive medications scheduled at 4:00 PM and 8:00 PM on 4/6/10.	W 368		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conduct an investigation when a Resident refused to participate in a fire drill at Chinook house. Findings include: Review of the facility fire drills on 6/29/10 revealed the fire drill for Chinook house dated 5/11/10 for the afternoon shift revealed a Resident was sleeping and refused to participate in the drill. The facility did not investigate this incident to determine if some kind of corrective action was needed. Interview with the administrative staff on 7/1/10 verified the facility had not investigated the incident.	W 448	W 448 Fire Evacuation Drills For Fire Drills cited IDT will investigate circumstance of resident refusal and develop a written Plan of Correction to ensure clients leave building during fire drill. PERSON RESPONSIBLE: ACM/IDT MONITOR: DDA2 DDA 2 will review all fire drill reports Monthly and ensure that if a client refuses to leave the building that the IDT will investigate circumstances of why client refused to leave and develop a plan of correction for that client. PERSON RESPONSIBLE:ACM/IDT MONITOR: DDA2	On-Going
W 449	483.470(i)(2)(iv) EVACUATION DRILLS	W 449		

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W 449	Continued From page 10 The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to develop a plan of correction (PoC) when a Resident refused to participate in a fire drill at Chinook house. Findings include: Review of the facility fire drills on 6/29/10 revealed a Resident refused to participate in a fire drill held on 5/11/10. The facility did not write a PoC to insure the Resident participated in future fire drills. Interview with administrative staff on 7/1/10 verified no PoC had been written.	W 449	W 449 Fire Evacuation Drills For Fire Drill cited facility will develop a written Plan of Correction for client that refused to participate in drill on 05/11/10 PERSON RESPONSIBLE: ACM/IDT MONITOR: DDA2 DDA 2 to In-service Attendant Counselor Manager on requirements of written plans of correction pertaining to fire drills when issues arise PERSON RESPONSIBLE: DDA2 MONITOR: DDA2	08/05/10 07/19/10
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, record review, and interview verification, it was determined the facility failed to insure staff followed the facility procedure for the prevention and control of infections. A staff and resident were observed making sandwiches for lunch for residents of the facility without putting on disposable gloves or washing their hands between touching the food and dirty/contaminated objects. Findings include: Observations on 6/29/10 at [redacted] house revealed a direct care staff and Sample Resident #5 were in the kitchen making	W 455	W 455 Infection Control In-service all direct care staff on the facility procedure for prevention and control of infections while handling food PERSON RESPONSIBLE: ACM MONITOR: DDA2	07/26/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 455	Continued From page 11 sandwiches for other residents. Neither the staff nor Resident #5 wore gloves at any time. The staff and Resident #5 were observed touching dirty objects during the sandwich making process (i.e. scratching touching hair, the counter, a used serving dish, turning on the faucets). Neither the staff nor Resident #5 washed their hands after touching any of the dirty objects. Review on 7/1/10 of the Food and Nutrition Services staff orientation PowerPoint presentation and the orientation handout Cleanliness Helps Prevent Food borne Illness (no date) revealed the facility's training materials included food safety practices which included washing hands and wearing gloves. Interview on 7/1/10 with a facility administrator verified that staff and residents who are making sandwiches for other residents must wear gloves and change those gloves any time they touch anything which may be contaminated before touching the sandwiches again.	W 455		

(10)(f)(iv) A compilation of findings since fiscal year 2010 by the Centers for Medicare and Medicaid Services, and Residential Care Services, at the Residential Habilitation Centers, Nursing Facilities, Supported Living, Assisted Living, Group Homes, Companion Homes, Adult Family Homes, and all other community based providers.

- Rainier School PAT E SODs 2015 – 2010

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600
July 6, 2015

BY FACSIMILE and CERTIFIED MAIL 7007 1490 0003 4297 1035

Important Notice – Please Read Carefully

Harvey Perez, Superintendent
Rainier School PAT E
PO Box 600
Buckley WA 98321

RE: Recertification Survey and Complaint Investigation 3075591
June 22, 2015 through June 26, 2015

Dear Mr. Perez:

From June 22, 2015 through June 26, 2015 survey staff from the Residential Care Services (RCS) Division of the Aging and Disability Services Administration (ADSA) conducted a complaint investigation/recertification survey at your facility. Based on that survey and investigation, RCS determined that Rainier School PAT E is out of compliance with two federal conditions of participation (COP) requirements for ICFs/IID participating in the Medicaid Title XIX ICF/IID program. Compliance with all COPs, found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The recertification survey and complaint investigation completed on June 26, 2015, found that Rainier School PAT E failed to comply with the following COPs:

W102-42 CFR 483.410-Governing Body

Specifically, the following governing body requirements were found not met:

W104 CFR 483.410 (a) (1) exercise general operating direction over the facility

W195-42 CFR 483.440-Active Treatment

Specifically, the following active treatment requirements were found not met:

W196 CFR 483.440 (a) (1) Each client receives active treatment

W206 CFR 483.440 (c) (1) (ii) Each program meets the individual's needs
W214 CFR 483.440 (c) (3) (iii) Identifies specific developmental and behavioral needs
W229 CFR 483.440 (c) (4) (i) Objectives stated in single and separate outcomes
W231 CFR 443.440 (c) (4) (iii) Objectives expressed in behavioral terms that are measurable
W234 CFR 443.440 (c) (5) (i) Training programs describe the methods to be used
W253 CFR 443.440 (c) (2) Data relates to the client's plan and assessment
W257 CFR 483.440 (1) (ii) Revise plan when objective is not being met
W436 CFR 483.440 Furnish and maintain equipment in good repair

The deficiencies are described in CMS Form 2567, a copy of which is attached. The cited deficiencies indicate limitations in Rainier School PAT E's capacity to provide adequate operating direction and active treatment services to clients. Significant corrections will be required before the facility can be found to be in compliance.

Remedy
Substantial compliance with federal requirements must be achieved and verified by September 24, 2015 (90 days from the date on which the survey was completed (SOM 3012)). Failure to achieve substantial compliance with 42 CFR 483.410 Governing Body and 42 CFR 483.440 Active Treatment may result in termination from the Medicaid ICF/IID program (42 CFR 442.101 (3) (e); SOM 3005 E).

Allegation of Compliance
When you believe the COP deficiencies have been corrected, please provide the ICF/IID Quality Assurance Administrator with a written credible allegation of compliance. The credible allegation should address the deficiencies cited under 42 CFR 483.410-W102 Governing Body and 42 CFR 443.440-W195 Active Treatment. The letter should describe: (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur.

If Rainier School PAT E makes a credible allegation of compliance, the ICF/IID survey team will revisit to determine whether compliance or acceptable progress has been achieved. Only two revisits are permitted, one no later than August 10, 2015 (within 45 days of the date on which the survey was completed), and one between August 11, 2015 and September 24, 2015 (between the 46th and 90th days (SOM 3012)). The compliance decision by RCS needs to be finalized no later than September 24, 2015. RCS will require at least five working days to complete a credible allegation survey and make a decision regarding compliance. Please plan accordingly if you want RCS to be able to complete a credible allegation survey before September 24, 2015.

If upon the subsequent revisit, your facility has not achieved substantial compliance, the termination or denial of payment for new admissions will be imposed. A revisit will not be conducted if a letter of credible allegation is not received by RCS. The COP will need to be found to be in substantial compliance before certification can be continued.

Plan of Correction (POC)

At this time you may voluntarily submit a POC, however, the POC will not halt the termination proceedings. The department will proceed with termination until you have achieved substantial compliance with the Conditions of Participation (CoPs). The COPs must be verified on-site by RCS as substantially implemented by September 24, 2015. At the time you achieve substantial compliance with the COPs, you will be required to submit an acceptable POC for any remaining standard level deficiencies. If and when you do submit a POC, it must be approved by RCS.

An acceptable POC must contain at a minimum the following core elements (SOM 3006.5):

1. How the corrective action will be accomplished for the sample Individuals found to have been affected by the deficient practice;

2. How the facility will identify other Individuals who have the potential to be affected by the same deficient practice, and how it will act to protect Individuals in similar situations;

3. What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;

4. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and

5. When corrective action will be accomplished.

Informal Dispute Resolution (IDR)

You may request an IDR of the deficiencies on which this action is based. RCS must receive your request for an IDR no later than July 16, 2015. To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a written credible allegation of compliance within the time limits described above. The written IDR request should:

1) Identify the specific deficiencies that are disputed;
2) Explain why you are disputing the deficiencies; and
3) Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review)

If requested, an IDR will be scheduled. During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. The IDR process will not change the time frames stated in this letter, including the deadlines for achieving compliance and submitting a written credible allegation of compliance.

Alternate Remedy

In lieu of termination from the Medicaid program, the State Medicaid Agency (SMA) may choose to impose a Denial of Payments for New Admissions (42 CFR 442.118; SOM 3006). If the SMA chooses to impose the denial of payment remedy, you will be notified on or before the 60th day, August 25, 2015, and will be advised of any appeal rights at that time.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,

Gerald Heilinger, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services

Enclosure

cc: CMS Regional Office, Washington State ICF/IID Team
Bill Moss, Assistant Secretary of ALTSA
Kathy Morgan, Director of RCS
Donna Cobb, Senior Counsel
Evelyn Perez, Assistant Secretary of DDA
Donald Clintsman, Deputy Assistant Secretary of DDA
Janet Adams, DDA Office Chief
Larita Paulsen, DDA QM Unit Manager
Bruce Work, DDA Medicaid Compliance Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	06/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey and a Complaint investigation (3056207) conducted at Rainier School Pat E from 6/22/15 through 6/26/15. The survey extended into the Condition of Participation of Active Treatment. A sample of 12 clients was selected from a census of 119 clients. The expanded sample included 10 current clients. The survey was conducted by: Kurt Bundy Gerald Heilinger Kathy Heinz Diana Klages Terry Patton Shana Privett Jim Tarr The Survey Team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long Term Care Administration Department of Social and Health Services PO Box 45600 Olympia, WA 98504-5600 Telephone: 360-725-2405 Fax: 360-725-2642	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

iciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 100	Continued From page 1 related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by; Based on observation, interview and record review, the facility did not meet the Condition of Participation of Active Treatment Services. Findings Include: The facility did not meet the Condition of Participation (COP) of Active Treatment Services. The facility did not ensure 3 Clients received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports. See W195.	W 100		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observations, record review and interviews the facility failed to meet the Condition of Participation in Governing Body by not ensuring their own policies for reporting abuse, neglect and mistreatment to the State Agency were followed, and by not meeting the Condition	W 102		

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W 102	Continued From page 2 of Participation for Active Treatment. Findings Include: W104, W196	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record reviews and interviews the Governing Body failed to ensure their policies for reporting allegations of abuse, neglect and mistreatment were followed. In addition the facility failed to ensure protections for Clients included assessing for trauma when abuse was suspected. These failures prevented the State Agency from being aware of all allegations of abuse, neglect or mistreatment and ensuring Clients were assessed for psychological distress following allegations of abuse. Findings include: 1. A record review of a Client to Client Altercation record dated 4/16/15 revealed Client #22 hit Client #20 on the left side of her face, near the left eye, causing bruising and swelling. There was no record that Client #20 was assessed for psychological distress. A record review of the facility ' s Incident Management Map dated 7/17/14 of the D Major Category I Client to Client Serious section revealed there was no instruction to assess a client for psychological distress after a serious assault. 2.. A record review of a Client to Client Altercation record dated 4/16/15 revealed that Client #22 hit	W 104		

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W 104	Continued From page 3 Client #20 on the left side of her face, near the left eye, causing bruising and swelling. This assault was not reported to the State Agency. When interviewed Staff P referred to the facility Incident Management Map, dated 7/17/14 stated that this assault did not need to be reported to the State Agency. However, a review of the facility Incident Management Map revealed that this type of assault was classified as a P2 level Notable assault and should be reported to the State Agency. 3. A record review of a facility Incident Report and investigation revealed that on 3/22/15 Client #18 obtained frozen chicken nuggets from the facility and was found by an RN trying to swallow them whole. The RN performed the Heimlich maneuver to dislodge the chicken nugget. The investigation also revealed that frozen items like chicken nuggets were not to be left in the freezer but rather stored in a secured freezer. Staff P was interviewed on 6/24/15 and revealed that Client #18 was on a chopped diet due to difficulty swallowing. Staff P also reported that the incident was not reported to the State Agency. Staff P referred to the facility ' s Incident Management Map, dated 7/17/14, and identified this choking incident as being a Minor Hard Cough incident and did not need to be reported to the State Agency. However, a review of the Incident Management Map in the C Major Category I section, Health/Medical/Emergency revealed that choking episodes which do not self-resolve and back blows and/or abdominal thrusts are required to clear the airway must be reported to the State Agency. The Incident Management Map in the L Major Category I under the Abuse/Neglect/Mistreatment section revealed that instances of a client obtaining or ingesting food	W 104		

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W 104	Continued From page 4 not on their prescribed diets or when dietary directions within the Individual Habilitation Plan are given, must be reported to the State Agency.	W 104		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to encourage individuals to manage their financial affairs and teach them to do so to the extent of their capabilities for 2 of 12 Sample Clients (Clients #8 and #11). This failure prevented Clients from developing skills in handling their own money.. Findings Include: 1. On 6/22/15 at 3:15 PM, Client #8 went to the staff " station " located adjacent to the living area of the home and he was offered $3.00 dollars provided by staff. Client #8 and one staff person went to a nearby building to the vending machine that was in the building. He put the money in the machine and purchased Yogurt Pretzels. He took them back to the home (San Juan) where he ate his snack in the dining area. Client #8 was also observed in the Vocational Workshop on 6/22/15 at 2:00 PM. He was sorting clothes, placing clothes in the commercial washer and dryer and performing additional tasks as requested by the facility supervisor.	W 126		

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W 126	Continued From page 5 An interview on 6/22/15 at 3:00 PM with Staff I revealed Client #8 was able to handle some money for going to the coffee shop and using vending machines. It was the house practice to provide money to Clients from petty cash on a daily basis or as requested by the Client based on their needs. When asked if Client #8 could learn some steps related to money resulting in greater independence he felt that he could. An interview on 6/22/15 at 3:40 PM with Staff H revealed Client #8 was able to travel around campus independently, and worked daily in the vocational area. She stated she believed he earned money for the work performed. She was unaware if Client #8 had a program for money management, however, she stated she thought he could handle money with some assistance. She stated it was their routine to provide money from petty cash in the afternoon to some Clients for spending money. An interview on 6/23/15 at 3:30 PM with Client #8 revealed he was paid for his work. He indicated he picked up money from staff when he needed it. When asked if he carried his own money, he stated he did not. When asked what he liked to buy with his money he stated he liked to go out. When asked if he was able to move around the campus without staff, he stated he could do that and went to work on campus by himself. When asked how he would buy something, he stated he would ask staff. An interview on 6/24/15 at 10:15 AM with Staff J at the Vocational Workshop revealed Client #8 had no opportunity to spend money at work although he felt he was capable of doing so. This staff stated he thought the plan for money	W 126		

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W 126	Continued From page 6 management consisted of the allowable allotment for money within his SSI account. He was unaware of a money management program. This staff stated he thought Client #8 could use money for his immediate needs around the campus and handle small amounts of money. A record review on 6/25/15 at 8:35 AM for Client #8 revealed the Individual Habilitation Plan (IHP) dated 2/5/15 included a service plan #1156-AC whereby Staff would provide Client #8 opportunities to go off campus for his leisure and shopping trips and that staff should provide incidental training for money management skills. Item # 1161 of the same document stated Client #8 understood the process of exchanging money but was not able to identify coins or bills, by denomination and does not understand value concepts. The Activity Schedule dated 3/1/15 time 1730-2030 indicated Client #8 enjoyed participating in off campus trips that included shopping for food items and eating out. No other documentation was available or presented that indicated there was a formal program for money management for Client #8. An interview on 6/25/15 at 9:30 AM with Staff K revealed Client #8 did have access to money that he could use for shopping and trips to the thrift shop but acknowledged money could get misplaced so staff now managed this from the home. He stated in the past Client #8 would go to the machines in various buildings and the money had on occasion been misplaced. He stated the facility also had a credit card system whereby Clients were required to fill out forms for this with assistance and that amounts up to $50.00 could be withdrawn going through this process. He was unaware the extent of training	W 126		

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W 126	Continued From page 7 that was offered Clients using that system, but added Clients were assisted as needed. He also stated Client #8 routinely went off campus for shopping trips, dinners and recreational activities several times per month. He stated that staff routinely handled the money for those trips and when Clients needed money in 'larger' amounts. An interview on 6/25/15 at 2:00 PM with Staff N revealed Client #8 did participate in a supportive money program within the Community Integration program although it did not include identified objectives on which they took data to measuring progress. He described the program as one that was intended to maintain existing skills in this case with money management. Staff N stated he believed that Client #8 had considerable skill in this area, however, he believed additional training needs for Client #8 could be identified and he would benefit from a formal money management program. 2. On 6/23/15 during observation of Client #11 at 10:00 AM he was observed sorting condiments and creamers into a 10-hole board used for this purpose. Staff stated he was paid for this work and that he enjoyed working at the vocational workshop and enjoyed being paid. On 6/23/15 at 3:00 PM Client #11 was observed leaving the building and staff stated he was going for a walk. They stated he liked to go alone. He returned at 4:50 PM from his walk. On 6/24/15 at 8:30 AM Client #11 was again observed at the Vocational Workshop sorting condiments as part of his program for which he earned money. An interview on 6/23/15 at 3:00 PM with Staff Lf revealed Client #11 went for walks daily after work and he was entirely capable of doing so in	W 126		

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W 126	Continued From page 8 that he was able to travel the campus on foot and knew where he was at all times. She added Client #11 had many skills associated with his active treatment program and that he was learning to clean his room, showering, and wash and dry his own clothes. She stated Client #11 had been assessed for Money Management and she believed he had some skills for doing so. She stated although he currently had no program for money management, she believed he could benefit from money management specifically in the area of coin identification. An interview on 6/25/15 at 1:00 PM with Staff O revealed Client #11 had training in money management in the past. She believed he could go to the store and make a purchase and hold up fingers to understand the values involved. She stated he did not like to have to wait for change and he had some difficulty identifying coins. She agreed Client #11 might benefit from such training, however, for now he received needed monies from staff. A review of the record for Client #11 on 6/25/15 at 2:45 PM revealed the Comprehensive Functional Assessment (CFA) Item B (Power) No. 3 asked, what are training needs in managing their own money? The document indicated Client #11 did not comprehend his account balance and that he needed staff assistance so that he did not deplete his account balance. In the 'Outcome Benefit' section of the report #3 - Status, Item 2 indicated Client #11 worked consistently and seemed satisfied with the amount of money he earned from his job which was approximately $30.00 per month. Item 3 indicated Client #11 enjoyed shopping and eating out. In a review of the Individual Habilitation Plan (IHP) there was no	W 126		

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W 126	Continued From page 9 evidence of a program of money management for Client #11. There was no additional evidence provided or produced through the record to indicate Client #11 to suggest could not benefit from an program of money management.	W 126		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure that 2 allegations of possible abuse, neglect and/or mistreatment were reported to the State Agency. Failure to report allegations of possible abuse, neglect and mistreatment prevented the State Agency from being aware of incidents and being able to investigate to ensure Clients were safe. Findings include: 1. Record review of the Client to Client Altercation record dated 4/16/15 revealed Client #22 hit Client #20 on the left side of her face, near the left eye, causing bruising and swelling. Staff P revealed, during a 6/24/15 interview, that this Client to Client Altercation was not reported to the State Agency. Staff P revealed Client #20 only experienced minor injuries. In addition Staff P revealed that Client #22 had a Behavior Support Plan which staff followed. Staff P revealed that for these reasons the facility would	W 153		

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W 153	Continued From page 10 not typically report this altercation to the State Agency. Staff P referred to the facility Incident Management Map, dated 7/17/14, and identified this assault as being a P2 level Notable altercation, therefore, according to Staff P, this Client to Client altercation does not need to be reported to the State Agency. However, review of the facility Incident Management Map revealed that P2 level Notable assaults must be reported to State Agency. 2. Record Review of facility Incident Report #902737 revealed that on 3/22/15 Client #18 obtained frozen chicken nuggets from the facility and was found by an RN trying to swallow them whole. Staff P revealed, during a 6/24/15 interview, Client #18 is on a chopped diet due to difficulty swallowing. The facility 5-Day Investigation Report dated 3/30/15 notes that an RN found Client #18 choking on chicken nuggets and was having difficulty breathing. The RN directed staff to initiate an emergency response and the RN performed the Heimlich maneuver which cleared Client #18 ' s airway, allowing him to breathe freely. Staff P revealed during a 6/24/15 interview that this incident of Client #18 choking was not reported to the State Agency. Staff P referred to the facility Incident Management Map, dated 7/17/14, and identified this choking incident as being a Minor Hard Cough incident, therefore, according to Staff P, this Hard Cough incident does not need to be reported to the State Agency. Staff P revealed Client #18 was only considered an in-house code. Review of the facility Incident Management Map in the C Major Category I section for Health/Medical/Emergency section revealed that choking episodes which do not self-resolve and back blows and/or abdominal thrusts are required	W 153		

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W 153	Continued From page 11 to clear the airway must be reported to State Agency. Review of the facility Incident Management Map in the L Major Category I Abuse/Neglect/Mistreatment section revealed that instances of a client obtaining or ingesting food not on prescribed diets, when dietary directions within the Individual Habilitation Plan are given, must be reported to the State Agency.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the Qualified Intellectual Disabilities Professionals (QIDP) were effectively managing all aspects of Clients ' habilitation programs. Failure to have QIDPs effectively overseeing Clients ' at the facility puts them in jeopardy of not receiving services which would ensure progress toward placement in a less restrictive setting. Findings include: See W196, W206, W214, W229, W234, W231, W253, W257, and W436.	W 159		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to develop and	W 195		

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W 195	Continued From page 12 implement systems that resulted in Clients receiving ongoing assessments, training programs to meet their needs, consistently implemented plans, and regular oversight with updating of the plans. This failure resulted in Clients needs not being addressed, failure to progress on plans without changes, and spending large portions of time not engaged in activities designed to increase their independence. Findings include: See W196, W206, W214, W229, W234, W231, W253, W257, and W436.	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 12 Sample Clients (Clients #7 and #10) and 1 Expanded Sample Client (Client #13) received an aggressive program of services designed to meet their assessed needs. This failure prevented these Clients from having the opportunity to learn skills to increase their independence and move to a less restrictive living setting. Findings include:	W 196		

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W 196	Continued From page 13 1. Observations for Client #10 at [redacted] House (unless specified differently below) revealed: a. On 6/22/15 at 2:00 PM Client #10 was observed sitting on a rocking love seat outside and appeared to be asleep. At 2:10 PM he came inside the house. The observation ended at 2:17 PM with Client #10 sitting at a desk. Staff did not involve Client #10 in any training activities. b. On 6/22/15 at 3:48 PM Client #10 was observed standing around in the kitchen. He then went and sat on a couch. Later he went outside and sat down for a few minutes. He spent time sitting in the Attendant Counselor Manager ' s (ACM) office at the house. The observation ended at 4:53 PM when dinner was served. Staff did not involve Client #10 in any training activities. c. On 6/23/15 at 10:35 AM Client #10 was observed sitting in the ACM ' s office. At 10:53 AM he was still sitting in the ACM ' s office although she was not there. At 10:54 AM he came out of the office into the kitchen and staff cued him to wash his hands in preparation for lunch. The observation ended at 10:58 AM with Client #10 walking out of the house. Except for washing his hands, staff did not involve Client #10 in any training activities. d. On 6/23/15 at 2:55 PM Client #10 was observed at his home. He responded to the surveyor ' s presence by coming up to the surveyor but did not respond further to any interaction. At 3:00 PM he went outside but came back in a couple of minutes later. At 3:04 PM the nurse provided medical care which ended at 3:15 PM. At 3:29 PM Client #10 appeared at the facility Coffee Shop where a cooking program	W 196		

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W 196	Continued From page 14 was in progress for Clients from his house. He left at 3:32 PM without staff involving him in the program. At 3:40 PM Client #10 was observed back at his house walking around. AT 4:05 PM Client #10 had a snack which he ate independently. The observation ended at 4:25 PM after Client #10 had walked around his house and gone outside to sit for a while. Staff did not involve Client #10 in any training activities. e. On 6/24/15 at 8:06 AM Client #10 was observed sitting in a chair at his house. A few minutes later he went outside and was observed walking away from the house. At 8:30 AM Client #10 returned to the house and sat in a chair. Then he took off his outer shirt and staff took him into his bedroom. At 8:37 AM , several minutes after the staff exited the bedroom, Client #10 came out of the room with a new shirt on. Other than changing shirts, staff did not engage Client #10 in any training activities. f. On 6/24/15 at 10:19 AM Client #10 was observed sitting in a chair. At 10:34 AM he was observed sitting in the ACM ' s office although the ACM was not in the office. The observation ended at 10:40 AM with Client #10 still sitting in the ACM ' s office even though she was not there. Staff did not engage Client #10 in any training activities. g. On 6/24/15 at 2:08 PM Client #10 entered the house and sat in a chair. He went to the bathroom for a few minutes and then came out and was walking around the house. At 2:29 PM he went outside. Staff did not engage Client #10 in any training activities.	W 196		

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W 196	Continued From page 15 h. On 6/24/15 at 5:48 PM Client #10 was observed walking away from his house. He returned at 5:55 PM and sat in a chair. At 6:05 PM he went outside, but came back inside at 6:10 PM. At 6:12 PM he sat on the " B " side of the house where the TV was on. The observation ended at 6:23 PM. Staff did not engage Client #10 in any training activities. i. On 6/25/15 at 7:55 AM Client #10 opened the door as the surveyor knocked to enter the house. He then sat in a chair. At 8:03 AM he left the house. At 8:10 AM he was observed sitting on the " B " side of the house where the TV was on. At 8:29 AM after having breakfast, he was walking around. The observation ended at 8:53 AM. Except for breakfast, staff did not engage Client #10 in any training activities. Review on 6/25/15 of Client #10 ' s file revealed his Individual Habilitation Plan (IHP) dated 3/3/15 had three objectives related to his negative behaviors and four skill acquisition objectives for placing clothes in a laundry hamper, doing a household chore, and participating in both on-house and off-house activities. The IHP stated: " [Client #10 ' s first name] willingness to engage in his active treatment is dependent on his mood, his familiarity with the staff present and the level of attention he receives from the staff during any encounter " . The IHP did not give staff directions for how to interact with Client #10 during the normal course of his day apart from the specific objectives. Interview on 6/25/15 with Staff Q (who was filling in for the Qualified Intellectual Disabilities Professional) verified that he was difficult to engage in activities. She revealed he does not	W 196		

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W 196	Continued From page 16 have a work training program as he would not go to work. 2. Observations for Client #13 at [redacted] House revealed: a. On 6/23/15 at 10:35 AM Client #13 was observed sitting in a chair with his legs crossed and up on the chair. He had a large Lego type block in his hand. At 10:47 AM a staff touched, tickled and stroked him near the head. At 10:53 AM a staff got him to go wash his hands for lunch. He was then taken to a couch where he laid down. At 10:57 AM the observation ended when he was taken to the bathroom with wet pants. Other than washing his hands, staff did not engage Client #13 in any training activities. b. On 6/23/15 at 3:00 PM Client #13 was observed wandering in the hallway. A staff assisted him to a vibrating couch and he laid down and curled up. At 3:20 PM a staff assisted him to sit outside in the sun. The observation ended at 3:22 PM and staff had not engaged Client #13 in any training activities. c. On 6/23/15 at 3:42 PM Client #13 was observed curled up in a chair at his house. At 4:00 PM he appeared asleep. At 4:05 PM staff did his garbage can program with him which took less than 3 minutes. He was then placed in a rocking chair and given a vibrating object. At 4:20 PM a staff attempted to play a game involving lights with him but he did not engage in the activity. (Client #13 is blind.) The observation ended at 4:25 PM when the staff took him to the bathroom. The only training activity was a garbage program and an attempt at an activity which did not really fit with his disabilities, staff did	W 196		

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W 196	Continued From page 17 not engage Client #13 in any training activities. d. On 6/24/15 at 8:10 AM Client #13 was observed sitting in a rocking chair with his legs crossed and pulled up onto the chair. At 8:16 AM staff took him to the bathroom. At 8:22 AM he came out of the bathroom. At 8:25 AM staff took him back into the bathroom. At 8:44 AM staff assisted him out of the bathroom and back into the rocking chair. The observation ended at 8:47 AM. Staff did not engage Client #13 in any training activities during this observation. e. On 6/24/15 at 10:10 AM Client #13 was observed sitting crossed legged in a chair in the kitchen while staff was assisting other Clients with a task there. At 10:20 AM he was observed holding a toy building block. At 10:30 AM Client #13 was taken to the living room where he sat in a chair holding the block. At 10:34 AM he was tapping the block against his teeth. The observation ended at 10:40 AM with Client #13 still sitting in the rocking chair. Staff did not engage Client #13 in any training activities during this observation. f. On 6/24/15 at 1:55 PM Client #13 was observed sitting in the rocking chair holding the toy building block. At 2:17 PM a staff took him to the bathroom. At 2:25 PM staff brought him from the bathroom to a chair in the living room. The observation ended at 2:32 PM. Staff did not engage Client #13 in any training activities during this observation. g. On 6/24/15 at 5:50 PM Client #13 was observed sitting on the vibrating couch. He was not engaged in an activity. At 6:05 PM he was observed curled up on the couch and appeared	W 196		

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W 196	Continued From page 18 asleep. At 6:06 PM staff took him to the bathroom. At 6:11 PM he came out of the bathroom and staff escorted him back to the couch. The observation ended at 6:24 PM with Client #13 still sitting on the couch. Staff did not engage Client #13 in any training activities during this observation. h. On 6/25/15 at 8:10 AM Client #13 was taken to the living room after breakfast and he went to the vibrating couch and sat down. At 8:10 AM he was in the bathroom. At 8:38 AM he came out of the bathroom naked. When the staff observed him they took him to his bedroom. The observation ended at 8:44 AM with Client #13 still in his bedroom. Staff did not engage Client #13 in any training activities during this observation. Review on 6/25/15 of Client #13's file revealed his IHP dated 6/9/15 noted his visual deficits. It noted that "... he is much more capable than initially thought, especially when staff have high expectations". He was noted to be 49 years old but there was no mention of being involved in a work training program although access to work training was something the IHP indicated would be needed for a community placement. Interview on 6/25/15 with Staff Q (who was filling in for the Qualified Intellectual Disabilities Professional) revealed that he often got overlooked as he appeared content to sit. She verified that staff saw him as being able to do more than one might first be led to believe. 3. All observations of client #7 included him wearing a [redacted] Observation on 6/22/15 at [redacted] House between	W 196		

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W 196	Continued From page 19 1:15PM and 1:45 PM revealed Client #7 sat in a wheelchair propelling himself around the living area of the home. He was observed manipulating a puzzle made of wood blocks. He ate a bag of corn chips. Staff cued him to throw away the empty bag which he did independently. Observation on 6/22/15 at [redacted] House between 2:30 PM and 3:15 PM revealed Client #7 was observed sitting in a wheelchair propelling himself around the living/dining area of the home with either a wooden puzzle on his lap or holding a small fabric sport ball. At one point he manipulated some plastic building blocks. Client #7 slapped Staff C on the bottom. Staff C stated "where are your hands supposed to be." Staff did not engage him in any training activity. Observation on 6/23/15 at [redacted] between 5 PM and 5:20 PM revealed Client #7 sat by a window. He was wearing a thick, long sleeve shirt. It was noted to be 89 degrees outside. There were no staff in the area. Observation on 6/24/15 at [redacted] House between 8:15 AM and 9 AM revealed client #7 sat in his wheelchair holding a wooden puzzle. He had a long sleeved sweatshirt on and propelled himself around the room independently. A staff attempted to put sun screen on Client #7 before he left for work but Client #7 refused. Client #7 reached out and slapped at a peer. Staff stated to Client #7 "that's not a nice way to play." Client #7 hit at the staff with a pillow and then attempted to kiss the staff's hand. Staff stated, "we can shake hands." Staff invited Client #7 to sit at the table but Client #7 refused. Client #7 hit a staff two times on the arm. The staff stated "we don ' t do that." Staff were overheard talking about the			

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W 196	Continued From page 20 weather and how hot it was outside. Staff did not engage him in any training activity. Observation on 6/24/15 at a vocational workshop located on campus between 10:15 AM and 10:35 AM revealed Client #7 sat in a wheelchair. He was wearing a long sleeve shirt and a coat. Client #7 handed paper to a peer who in turn shredded the paper. Staff asked Client #7 to shred his own paper but Client #7 continued to give the paper to his peer. The surveyors noted the air conditioner was not on. Staff were observed wearing a short sleeved shirt and shorts. Observation on 6/24/15 at [redacted] House between 1: 50 PM and 2:10 PM revealed Client #7 was sitting in a wheelchair by a window. He was wearing a black coat. He ate a snack between 2:10 PM and 2:30 PM. Between 2:30 PM and 2:45 PM he sat by the window of the home. Staff did not engage him in any training activity. Observation on 6/24/15 which started at [redacted] House at 3:40 PM and ended at the facility gym at 4:05 PM revealed staff brought Client #7 out of the bathroom and left him by the door. He was observed wearing a coat. Staff were asked if there was a plan for the afternoon. Staff stated "they were going to the gym " . When asked what they were going to do in the gym, staff stated "they would figure it out when they got there." Client #7 was wheeled to the gym by staff. The floor of the gym was covered with dust. Construction appeared to be going on in the building. Client #7 played catch with the staff using a basketball. Client #7 hit the staff on the bottom and the staff stated "no , no, no, no, no, sir." Client #7 hit the staff again. Staff stated to	W 196		

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W 196	Continued From page 21 Client #7, "where do your hands go." The surveyor left the observation due to the extreme heat and lack of air circulation in the gym. Staff did not engage Client #7 in any training activity. Observation on 6/24/15 at [redacted] House between 4:10 and 4:20 PM revealed Client #7 returned from the gym with staff. His coat was on and his face was flushed. No Staff encouraged him to take his coat off. Staff did not engage Client #7 in any training activity. Observation on 6/25/15 at [redacted] House between 8:15 AM and 8:50 AM revealed Client #7 was sitting in a wheelchair propelling himself around the house. He was wearing a long sleeve shirt. Staff asked Client #7 if he wanted to join his peers at the table. Client #7 propelled himself to a side table and opened a drawer. Client #7 took nothing from the drawer. Client #7 started pointing outside. Staff asked Client #7 if he wanted to work on an "activity." Client #7 kissed the staff's hand two times. Staff stated "ok, thank you." Staff M looked for a "water toy" for Client #7. Client #7 was observed looking out the window in the living area of the home. Staff M asked Client #7 if he wanted to pass the football. Staff M tossed the ball to Client #7. Staff did not engage Client #7 in any training activity. Interview with Staff M on 6/25/15 about the purpose of the ball toss revealed it was considered an activity to engage Client #7 in socialization. Record review on 6/25/15 of the IHP date 4/21/15 revealed objectives in the following areas: 1. Participate in socialization to decrease slapping, pinching or poking at people. 2. Increase	W 196		

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W 196	Continued From page 22 socialization with peers to develop relationships and find new leisure activities he might be interested in. 3. Increase self-care to decrease dependency on staff. 4. Increase physical strengths/ ability to move around independently by walking with walker. Interview with Staff O on 6/25/15 revealed Client #7 was working on socialization and self-care skills.	W 196		
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to develop a plan for 1 of 12 sampled Clients (#6) walking around the house naked. Failure of the facility to address this need placed the Client at risk for potential loss of dignity, risk for being humiliated and being sexually targeted. Findings include: Observations on 6/22/15 during the initial tour of [redacted] house revealed Client #6 ' s room was located on the male side of the house. A total of 4 men and 4 women were living in the home.	W 206		

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W 206	Continued From page 23. All records were reviewed on 6/25/15; Record review of the interdisciplinary progress note dated 2/9/15 revealed Client #6 "kept walking out of her room naked. " Record review of the interdisciplinary progress notes revealed that on 5/4/15, Client #6 walked into the living area of the home naked. Review of the interdisciplinary progress note dated 6/16/15 revealed that Client #6 kept "coming out of her room naked and lying on the couch in the nude on the B side. She is also coming out into the common areas naked. Two male peers seemed to be fixated on her. She is not easily redirected to her room or the bathroom to get dressed." Record review of the interdisciplinary progress noted revealed on 6/18/15 that Client #6 "came out of her bedroom and laid naked on the couch." Record review of the interdisciplinary progress note revealed that on 6/21/15 that Client #6 "came out of her room naked 3 times." Record review of Client #6 ' s Individual Habilitation Plan (IHP) dated 7/1/2014 revealed there was no program to address the behavior. The first incident of public nudity, occurred on 2/9/15. Since the occurrence, there were no changes made to the IHP. Interview with Staff E on 6/25/15 revealed that she wrote the progress note on 6/16/15 and that she had been made aware that Client #6 was lying on the couch without clothing by one of the	W 206		

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W 206	Continued From page 24 male clients. Interview with the Staff B on 6/25/15 revealed she was aware of the behavior however she forgot to mention it at the weekly house team meeting. Interview on 6/25/15 with Staff R assigned to Client #6 and Staff Q revealed that they were unaware of the behavior. The facility had not developed a plan to address the behavior of Client #6 entering common areas of the home naked.	W 206		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to identify Client #6 ' s behavioral needs when she repeatedly walked around her house naked. Failure of the facility to identify this behavioral need resulted in Client #6 not having a plan to support her needs. Findings include: Observations on 6/22/15 during the initial tour of [redacted] house revealed Client #6 ' s room was located on the male side of the house. A total of 4 men and 4 women were living in the home. All records were reviewed on 6/25/15: Record review of the interdisciplinary progress note dated 2/9/15 revealed Client #6 "kept	W 214		

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W 214	Continued From page 25 walking out of her room naked. " Record review of the interdisciplinary progress notes revealed that on 5/4/15, Client #6 walked into the living area of the home naked. Review of the interdisciplinary progress note dated 6/16/15 revealed that Client #6 kept "coming out of her room naked and lying on the couch in the nude on the B side. She is also coming out into the common areas naked. Two male peers seemed to be fixated on her. She is not easily redirected to her room or the bathroom to get dressed." Record review of the interdisciplinary progress noted revealed on 6/18/15 that Client #6 "came out of her bedroom and laid naked on the couch." Record review of the interdisciplinary progress note revealed that on 6/21/15 that Client #6 "came out of her room naked 3 times." Record review of Client #6 ' s Individual Habilitation Plan dated 7/1/2014 revealed there was no assessment of the behavior. Interview with Staff B on 6/25/15 revealed she was aware of the behavior however she forgot to mention it at the weekly house team meeting. Interview on 6/25/15 with the Staff R assigned to Client #6 and Staff Q revealed that they were unaware of the behavior. The facility had not assessed the behavior.	W 214		
W 229	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan	W 229		

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W 229	Continued From page 26 must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 12 Sample Clients (Client #2) had an objective that could be measured in singular, behavioral outcomes. Failure of the facility to ensure that objectives are written in singular, behavioral, measurable terms, prevented staff from determining which specific skill set the client is learning, maintaining or losing skills in. Findings include: Review of an Individual Habilitation Plan dated 3/5/15 revealed Client #2 had an objective that read "Given three verbal cues, [Client #2 ' s first name] will demonstrate each of four skills to care for clothes/shoes with an average of 3.0 for three consecutive months." The 4 skills include hanging clothes in closet, putting folded, clean clothes in a drawer, put soiled clothes in a hamper and put shoes on a shelf in the bottom of the closet. The 4 separate skills did not form a continuous, sequential routine that could be run in a single setting. Staff recorded data for each of the individual skills of the routine and not for the completion of the entire routine. Interview with the Staff O on 6/25/15 revealed that the program was designed to maintain a routine and that it wasn ' t singular.	W 229		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN	W 231		

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W 231	Continued From page 27 The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an objective for 1 of 12 sample Clients (Client #2) was written in terms that would provide for accurate measurement of his progress. The facility put 4 separate skills together as a singular objective but the skills did not form a sequential routine. Client #2 did not know and perform these skills independently so the facility could not then use them to form a singular routine. Failure to write objectives terms that are measurable, prevented the facility from determining whether or not the objective had been met. Findings include: Review of an Individual Habilitation Plan dated 3/5/15 revealed Client #2 had an objective that read " Given three verbal cues, [Client #2 ' s first name] will demonstrate each of four skills to care for clothes/shoes with an average of 3.0 for three consecutive months." The 4 skills include hanging clothes in closet, putting folded, clean clothes in a drawer, put soiled clothes in a hamper and put shoes on a shelf in the bottom of the closet. The 4 separate skills did not form a continuous, sequential routine that could be run in a single setting. Staff recorded data for each of the individual skills of the routine and not for the completion of the entire routine. Interview with Staff O on 6/25/15 revealed the data scores would not reflect his skill level.	W 231		

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W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that training programs developed for 1 of 12 Sample Clients (Client #10) and 1 Expanded Sample Client (Client #13) contained clear and sufficient directions and details to provide for consistent implementation by all staff working with the Clients. This failure put Clients at risk of not making progress on programs. Findings include: 1. Review on 6/25/15 of Client #10 ' s file revealed the Individual Habilitation Plan (IHP) stated: " [Client #10 ' s first name] willingness to engage in his active treatment is dependent on his mood, his familiarity with the staff present and the level of attention he receives from the staff during any encounter " . Review on 6/25/15 of Client #10 ' s Program Book revealed he had programs for placing dirty clothes in the hamper, participating in an off house recreational activity, engaging in an on house activity, and assisting staff with a household chore. Review of the program instructions for staff revealed all four programs had identical instructions to staff. The cue was " [Client #10 ' s first name] help me with _____ " , the reinforcer was " lavish praise indicating what he is doing and spending bit of time with him as he starts the activity " , and the correction was " Re-cue assist as needed " . Interview on 6/26/15 with Staff A verified the instructions were not detailed and would make it	W 234		

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W 234	Continued From page 29 difficult for all staff to implement the program exactly the same. 2. Review on 6/25/15 of Client #13 ' s file revealed his IHP contained objectives for tooth brushing, placing a garbage bag into a larger container, rubbing lotion on his legs, and staying at an activity table for 10 minutes. Review of the Program Book for Client #13 revealed all four of the programs contained a data scoring code which included tactile prompts. However, none of the four programs made a reference to tactile cues and what they were. The programs also did not reference when the tactile cue should be used. Interview on 6/26/15 with Staff A verified the programs did not contain reference to what the tactile cue was that was to be used or when it was to be used.	W 234		
W 253	483.440(e)(2) PROGRAM DOCUMENTATION The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that significant events and changes in 2 of 12 Sample Clients (Clients #6 and #12) and 1 Expanded Sample Client (Client #16) were documented in the Clients ' records. This failure prevented the facility from ensuring there was a record of consideration of Clients ' rights being protected when changes were made and from having an accurate habilitation plan.	W 253		

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W 253	Continued From page 30 Findings include: 1. Observation of Client #12 on 6/22/15 at 1:15 PM revealed he was living alone in Columbia House where he was attended by two Direct Care staff at all times. Interview on 6/22/15 with Staff P revealed he had been moved to Columbia house (from Chelan House) in the recent past because of his serious aggressive behavior. Review on 6/25/15 of Client #12 ' s file revealed there was no documentation related to the reasons for the move. Interview on 6/26/15 with Staff P verified there was no documentation in Client #12 ' s file related to the reasons for the move. 2. Observation on 6/23/15 at 3:08 PM revealed Client #16 stated he wanted to go to the cooking class at the facility Coffee Shop. Staff F told him he couldn ' t go as everyone had already left. Review on 6/23/15 of Client #16 ' s Individual Habilitation Plan (IHP) revealed " On campus [Client #16 ' s first name] can self-transport, but prefers to have staff accompany him to known areas ". Interview on 6/23/15 with Staff F revealed Client #16 has dementia and he would get lost so she didn ' t let him go alone. She verified the IHP was not accurate. 3. Observations on 6/22/15 during the initial tour of [redacted] house revealed Client #6 ' s bedroom was located on the male side of the house. There were a total of 4 men and 4 women living	W 253		

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W 253	Continued From page 31 in the home. All records were reviewed on 6/25/15: Record review of the interdisciplinary progress note dated 2/9/15 revealed Client #6 "kept walking out of her room naked. " Record review of the interdisciplinary progress notes revealed that on 5/4/15, Client #6 walked into the living area of the home naked. Review of the interdisciplinary progress note dated 6/16/15 revealed that Client #6 kept "coming out of her room naked and lying on the couch in the nude on the B side. She is also coming out into the common areas naked: Two male peers seemed to be fixated on her. She is not easily redirected to her room or the bathroom to get dressed." Record review of the interdisciplinary progress noted on 6/18/15 revealed Client #6 "came out of her bedroom and laid naked on the couch." Record review of the interdisciplinary progress note on 6/21/15 revealed Client #6 "came out of her room naked 3 times." Record review of Client #6 ' s IHP dated 7/1/2014 revealed there was no program to address the behavior. The first incident of public nudity occurred on 2/9/15. Since the occurrence, there were no changes made to the IHP. Interview with Staff E on 6/25/15 revealed she wrote the progress note on 6/16/15 and she was made aware that Client #6 was lying on the couch naked by one of the male clients.	W 253		

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W 253	Continued From page 32 Interview with the Staff B on 6/25/15 revealed she was aware of the behavior, however she forgot to mention it at the weekly house team meeting. Interview on 6/25/15 with Staff R and Staff Q, revealed they were unaware of the behavior. The facility had not developed a plan to address the behavior of Client #6 entering common areas of the home naked.	W 253		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that one Sample Client (Client #10) had changes to his programs when he failed to make progress toward the objective. This failure prevented Client #10 from learning the identified skills and becoming more independent. Findings include: 1. Review on 6/25/15 of the Qualified Intellectual Disabilities Professional (QIDP) review of Active Treatment dated 4/17/15 for Client #10 revealed the following: a. The data for Objective 3009 (a self-calming	W 257		

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W 257	Continued From page 33 technique) revealed his progress for January, 2015 was 50%, for February it was 25% and for March it was 61%. The program goal was 96% progress. Review of monthly data from August, 2014 through January, 2015 revealed a steady decline in progress and showed a significant decline in January, 2015. The QIDP summary stated " Program declining, but within normal variation historically ". There was no reference to any changes to the program to encourage success. b. The data for Objective 9002 (physical aggression) revealed his progress for January, 2015 was 2 episodes, in February it was 5 episodes and in March, it was 2 episodes. Data from June, 2014 to December, 2014 showed a range from 2 to 11 episodes. The QIDP summary stated " Within normal variation ". Interview on 6/25/15 with Staff Q (who was filling in for the QIDP) verified programs had not been changed when progress was not being observed.	W 257		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 Sample clients (Clients # 4, #7 and #10) and 1 Expanded Sample Client (Client #13) received a physical exam annually. This failure put Clients at risk of having medical conditions not being identified and treated.	W 322		

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W 322	Continued From page 34 Findings Include: 1. A record review on 6/25/15 of Client #4 ' s health records revealed his most recent physical examination was on 4/15/14. A 6/25/15 interview with Staff Q verified there was not a more current physical examination. 2. A record review on 6/25/15 of Client #10 ' s health records revealed his most recent physical examination was on 4/2/14. A 6/25/15 Interview with Staff Q verified there was not a more current physical examination. 3. A record review on 6/25/15 of Client #13 ' s health records revealed his most recent physical examination was on 4/1/13. A 6/25/15 Interview with Staff Q verified that there was not a more current physical examination. 4. A record review on 6/25/15 revealed Client #7 ' s health records revealed his most recent physical examination was 3/8/2013. Interview with Staff Q on 6/25/15 revealed she was unable to locate the documentation that there was a more current physical examination.	W 322		
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING . The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medications were kept secured until they were administered	W 382		

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W 382	Continued From page 35 as prescribed. This failure resulted in medications being unaccounted for and putting Clients at risk of ingesting medications not prescribed for them. Findings include: Review on 12/16/14 of a preliminary facility investigation into an incident that occurred on 12/3/14 revealed Staff A, a facility nurse, transported two Senna/Docusate (treatment for constipation) pills from the nursing office, in a paper bag, to Chelan House sometime around or shortly after 2:15 PM. This medication was to be started the next day. The facility investigation indicated that Staff A put the pills, still in the paper bag, on the counter in the medication room upon arriving at Chelan House. Staff A then completed the 3 PM and 8 PM medication passes at Chelan house. At this point he started the process of recording and documenting the Senna/docusate medication that had been brought to the house. Staff A discovered the paper bag was missing. He immediately notified the proper staff and initiated a search. The missing medication was not found. Observation on 2/25/15 of the medication room at Chelan House revealed it is too small to pass medications to Clients from within the room. The medication cart, which contains Clients' medications, takes up too much of the room to allow the nurse to be in the medication room with the medication cart and still administer the medications. The door to the medication room was noted to have a locking mechanism that kept the door locked at all times, whether the door was closed or left open. So, if the door to the medication room was closed, the room would be	W 382		

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W 382	Continued From page 36 secured. Further observation of the door revealed it had an attached stopper which would allow the door to be propped open. Interview on 2/25/15 with Staff B revealed he conducted part of the investigation into the incident. He believes the most likely explanation is that Staff A was administering medications from the cart, outside the medication room. He believes the door to the medication room was propped open and a Client entered the room, un-noticed by Staff A, and took the bag of pills.	W 382		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to furnish, maintain in good repair, and teach clients to use and to make available eye glasses for 1 of 12 Sample Clients (Client #8) in the sample. This failure prevented the Client from having access to eye glasses. Findings Include: On 6/22/15 at 1:40 PM Client # 8 did not have glasses as he went to buy a snack on an adjacent building. Client #8 was blind in his left eye and by virtue of standing very close to the machine and seeming trying to see, there were indicators he	W 436		

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W 436	Continued From page 37 had difficulties visually at the machine in his attempt to make his choice. On 6/23/15 at 7:00 AM during an observation of Client #8 there was no evidence of eyeglasses in use for his morning meal. He was again observed at the Vocational Program at 9:00 AM where his work involved sorting clothing from light to dark colors. He also pushed the buttons for the automated washing and drying machines. There was no evidence of eyeglasses in use during these tasks. Client #8 was observed at 3:30 PM back on the home and he did not have glasses as he assisted in setting the table. Client #8 was observed in the Workshop laundry at 9:55 on 6/24/15 as he was sorting children clothing from adult clothing and hanging them on hangers. He was never observed with eye glasses. An interview with Staff K on 6/25/15 at 9:30 AM revealed Client #8 was to wear glasses but they were being repaired at this time. When asked how long eyeglasses repair takes he stated it could take several weeks. When asked if he had any documentation regarding the process in this case he thought that he did, however, this was never presented. He was uncertain as to when the request had actually been made for the repair. When asked when the last assessment for ophthalmology had occurred he was uncertain and although he checked documentation, he was unable to find any consult for the glasses or a referral to ophthalmology. An interview on 6/25/15 at 2:00 PM with Staff N revealed Client # 8 had eyeglasses, however, he always destroyed them. When asked if any training had been provided for this behavior he stated he didn't know of any, however, the discussion had resulted in allowing for the	W 436		

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W 436	Continued From page 38 provision of reading glasses. When asked if Client #8 had reading glasses he responded that he believed he did. When asked when Client #8 was to wear them or where they might be located he stated they would be on the home and staff should encourage him to wear them. Staff N acknowledged the confusion regarding the need and the practice associated with the glasses for Client #8 and stated he was going to have to re-initiate this process to determine the actual need and status of the glasses for Client #8. An interview on 6/25/15 at 4:30 PM with Staff I revealed he was uncertain as to whether or not Client #8 required eyeglasses, but acknowledged he had reading glasses and located them in the staff drawer. He stated the reading glasses were of a 1.5 power. When asked why Client #8 was not wearing the glasses he stated because he had a history of breaking them. He was not aware of any plan for dealing with that. Following a review of the Individual Habilitation Plan (IHP), Staff I agreed the matter needed to be re-assessed as there was confusion regarding the intended use of eyeglasses and/or reading glasses. On 6/25/15 at 2:45 PM during record review for Client #8 within the IHP dated 2/5/15 in the section Adaptive Equipment Prescription Eyeglasses/readers were identified. The reason listed stated the [redacted] was non responsive with [redacted] removal. His glasses were needed to greatly aid his vision, both far and near, but can benefit most from their use for close up work. Reader glasses with +2.75 strength may also benefit him or close up work while seated - vs.	W 436		

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RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 39 the expense of RX glasses that may break frequently." In the 'schedule' section of this document it stated staff need to continue to supervise use of the glasses at meal time, work task, arts and crafts, games, TV watching, etc., where close up eye work is needed and he is more engrossed in the activity due to interest. Glasses will be maintained and cleaned by staff until his tolerance and use is consistent - store in A side cupboard on the house and at the job site. There was no evidence of program for the care, cleaning or use of eyeglasses for Client #8.	W 436		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

January 31, 2014
CERTIFIED MAIL (7008 1300 0000 7188 4481)

Neil Crowley, Superintendent
Rainier School PAT E
PO Box 600
Buckley, WA 98321

RE: Recertification Survey
1/13/2014 through 1/17/2014

Dear Mr. Crowley:

From 1/13/2014 through 1/17/2014 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ALTSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Loida Baniqued

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	01/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Rainier School Pat E from 01/13/2014 through 01/17/2014. Amended on March 28, 2014 as a result of an Informal Dispute Resolution. A sample of 12 residents were selected from a census of 121. The survey was conducted by: Terry Patton, R.N., B.S.N. Claudia Baetge, M.A. Christina Borchardt, R.N., B.S.N. Penelope Rarick, B.A. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Services Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2419 Fax: (360) 725-2642	W 000	RECEIVED APR 04 2014 DSHS-ADSA Residential Care Services ICF/MR Program	
W 438	483.470(h)(1) EMERGENCY PLAN AND PROCEDURES The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, facility failed to develop, implement, and keep current a written Disaster Plan to meet	W 438		3/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sept 4/4/14

efficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 438	Continued From page 1 all potential emergencies and disasters. Failure to have a current, updated Disaster Plan placed staff and residents at risk of harm if a disaster should occur. Findings include: All observations, record reviews and interviews occurred between January 16, 2014, and January 17, 2014. Record review revealed the following phone numbers in the January 23, 2013, Disaster Plan: Duty Office - Extension 4496 Emergency Preparedness Hotline 24/7 toll free number - 1-877-256-4859 RS Satellite phone number - 254-240-3750 Health Center - Extension 4297 Superintendent's Office - Extension 3000 Maintenance - 360-829-0258 Telephone calls placed by the State Surveyor to the phone numbers listed above verified the phone numbers were disconnected and/or did not connect to the location identified. Record review revealed the January 23, 2013 Disaster Plan identified the Disaster Supply Rooms in Cedar House as being stocked with a 7 day supply of the items listed below. However, observation of the Cedar House Disaster Supply Room revealed the items were not stocked or were stocked in lesser amounts. The actual amount of those Disaster supplies stocked in the Disaster Supply Room was;	W 438	Rainier School Disaster Plan will be reviewed/revised to meet potential emergencies and disasters. Phone numbers, locations and quantity of disaster supplies will be updated. **Person responsible:** QA Director **Monitor:** Asst. Superintendent PAT E staff will be trained in the updated Disaster Plan. Disaster Plan will be reviewed/revised yearly or as needed. Safety Committee will check emergency supply areas two times per year to ensure adequate supplies are available and have not expired. **Person responsible:** QA Director **Monitor:** Asst. Superintendent	Completed 2/28/14 3/14/14 and ongoing

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RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 438	Continued From page 2 Paper plates/cups - None stocked Toilet Paper - None stocked Plastic Utensils - A box of plastic spoons is stocked. No other utensils. Blankets/Pillows - Four boxes of blankets stocked. No pillows stocked. Flashlights and Batteries - None stocked Fire Extinguishers - None stocked Waterproof Tarps - None stocked Propane Lanterns - One propane lantern is in stock, there is no propane for it. Plastic Gloves - None stocked Dust Masks and Goggles - None stocked AM Radios - None stocked Sheets/Pillowcases - None stocked First Aid Kits - None stocked Record Review revealed the facility Disaster Plan dated January 23, 2013, noted portable space heaters could be used as a supplementary heat source. Interview with Staff A revealed portable space heaters were not permitted for use at the facility and the facility does not have any. The facility Disaster Plan noted in one section that emergency medication carts are located in the Rainier Building room 132. However, another section of the Disaster Plan noted the emergency medication carts are located in the Rainier Building room 123. The Rainier Building does not have a room 132. Room 123 is used for staff education and no emergency medication carts are located there. Interviews with Staff A and Staff B revealed they	W 438		

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W 438	Continued From page 3 were unaware of the failures by the facility to meet the requirements of the Disaster Plan. Staff A and Staff C revealed portable space heaters may not be used at the facility. Interview with Staff D revealed that the Emergency Medication Carts were located at sites throughout the campus and are not centrally located in the Rainier Building.	W 438	Rainier School Disaster Plan will be reviewed/revised to meet potential emergencies and disasters. Phone numbers, locations and quantity of disaster supplies will be updated. **Person responsible:** QA Director **Monitor:** Asst. Superintendent	Completed 2/28/14
W 439	483.470(h)(2) EMERGENCY PLAN AND PROCEDURES The facility must communicate, periodically review, make the plan available, and provide training to the staff. This STANDARD is not met as evidenced by: Based on interviews, the facility failed to periodically review and train staff to the facility's Disaster Plan. Failure to train staff to the Disaster Plan placed staff and residents at risk of harm if a disaster should occur. Findings include: The following interviews were conducted between January 13, 2014, and January 17, 2014. Staff G revealed that the facility's Disaster Plan is not included in required staff education. Staff A, Staff C, Staff H and Staff I revealed staff have not been trained by the facility to the facility Disaster Plan. When interviewed, Staff E, Staff H, and Staff I were unable to identify alternate water sources that were noted in the facility's Disaster Plan.	W 439	PAT E staff will be trained in the updated Disaster Plan. Disaster Plan will be reviewed/revised yearly or as needed. Safety Committee will check emergency supply areas two times per year to ensure adequate supplies are available and have not expired. **Person responsible:** QA Director **Monitor:** Asst. Superintendent	3/14/14 and ongoing
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441		

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W 441	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure evacuation drill times varied on day and afternoon shifts and different escape routes were used. Failure to ensure evacuation drills were conducted under various and realistic conditions and by means of different escape routes placed residents at risk of harm should an emergency occur that necessitates evacuation. Findings include: All record reviews, observations and interviews occurred between January 13, 2014 and January 17, 2014. Fire evacuation drills at Orcas House on the day shift were held at 1:44 PM on 01/28/13, 1:28 PM on 04/25/13, 1:30 PM on 07/29/13 and 1:26 PM on 10/29/13. Fire evacuation drills at Alpine House on the day shift were held at 12:55 PM on 01/24/13, 12:51 PM on 4/30/13, 1:36 PM on 07/09/13 and 01:10 PM on 10/29/13. Fire evacuation drill drills at Shasta House on the afternoon shift were held at 2:25 PM on 02/19/13, 2:25 PM on 05/28/13, 2:20 PM on 08/28/13 and 2:20 PM on 11/16/13. Fire evacuation drills at San Juan on the afternoon shift were held at 3:00 PM on 2/28/13, 2:45 PM on 05/14/13, 3:25 PM on 08/24/13 and 3:00 PM on 11/22/13. Observation at Orcas House revealed House Fire Evacuation plans posted at each exit door.	W 441	Rainier School Disaster Plan will be reviewed/revised to meet potential emergencies and disasters. **Person responsible:** QA Director **Monitor:** Asst. Superintendent PAT E staff will be trained in the updated Disaster Plan. Disaster Plan will be reviewed/revised yearly or as needed. **Person responsible:** QA Director **Monitor:** Asst. Superintendent	Completed 2/28/14 3/14/14 and ongoing

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W 441	Continued From page 5 displayed 6 potential evacuation routes. This included: 3 front door, 2 side door and 1 back door escape routes. Interview Staff L at Orcas on 01/17/14 revealed during fire evacuation drills residents always use one route and exit through the front door. Observation at Shasta House revealed House Fire Evacuation plans posted at each exit door displayed 6 potential evacuation routes. This included: 3 front door, 2 side door and 1 back door escape routes. Interviews Staff M on 01/14/14 and 01/17/14 at Shasta revealed during fire evacuation drills residents always exit through one of three front doors and not the side or back door exits. Record review of Facility Safety and Drill Reports did not identify which evacuation routes were used for each fire evacuation drill.	W 441		
W 444	483.470(l)(1)(iii) EVACUATION DRILLS The facility must hold evacuation drills to evaluate the effectiveness of emergency and disaster plans and procedures. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to evaluate the effectiveness of the January 23, 2013, Disaster Plan. Failure to evaluate effectiveness of the facility's Disaster Plan and ensure plans were adequate in the event of a disaster placed residents and staffs safety at risk. Findings include: The following interviews were conducted between January 13, 2014, and January 17, 2014:	W 444		3/14/14

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W 444	Continued From page 6 Staff A, Staff B, Staff C, Staff H and Staff I could not recall a time when the facility may have evaluated the effectiveness of the Disaster Plan.	W 444		

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ALTSA, RCS, ICF/IID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600
April 12, 2013
CERTIFIED MAIL (7007 1490 0003 4201 3384)

Neil Crowley, Superintendent
Rainier School PAT E
PO Box 600
2120 Ryan Road
Buckley, Washington 98321

RE: Recertification Survey
3/25/2013 through 3/29/2013

Dear Mr. Crowley:

From 3/25/2013 through 3/20/2013 ICF/IID survey staff from the Residential Care Services (RCS) Division of Aging and Long-Term Support Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/IID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2405 Fax (360) 725-2642

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2405.

Sincerely,

Paula Song for

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	03/29/2013

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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Rainier School PAT E on 3/25/13 to 3/29/13. A sample of 12 resident was selected from a census of 122. The Expanded Sample included 79 current residents. The survey was conducted by: Janette Buchanan, R.N., B.S.N. Penny Rarick, B.A. Christina Borchardt, R.N., B.S.N. Claudia Baetge, M.A. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: 360-725-2405 Fax: 360-725-2642	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure staff handled and stored food properly and failed to provide a well repaired and maintained environment which was free from	W 104	RECEIVED JUN 14 2013 DSHS/ADSA/RCS/BAAU	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Supt.	6/6/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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W 104	Continued From page 1 safety hazards for 5 of 8 cottages (Alpine, Aspen, Omak, Orcas, & San Juan). Failure to store and handle food properly could place residents at risk of food borne illness and failure to provide a well repaired and maintained environment could place residents at risk for injury. Findings include: All observations were between 03/25/13, 03/27/13 and 03/29/13 unless otherwise stated. Alpine: (Exterior) 1. Old barbeque moss growing on the wood, blocking the bicycle rack area 2. Patio under bedroom windows in the garden area was wood pieces stacked on the ground. 3. Charcoal barbeque was leaning up against the cottage in the flower bed Aspen: (Exterior) 1. Back patio area noted that there were lawn chairs and foot stools stacked on top of the glass top picnic table with hoses and cushions stacked on top of that 2. Under the windows a piece of wood stacked against the cottage with several other pieces laying on the ground 3. Window screen broken. 4. On the sidewalk there was a pile of bricks on the side Omak: (Exterior) 1. Torn landscaping fabric 2. Broken trellis 3. Landscaping border sections not completely buried in ground 4. Nails protruding from exterior siding (B side door) (Interior) Refrigerator:	W 104	PAT E house refrigerator/freezer food was assessed for labels and any food not labeled was thrown away. **Person responsible:** ACM **Monitor:** DDA2	Completed 5/24/13
			Any food product that is not prepackaged with expiration date will be labeled, identified and dated. **Person responsible:** ACM **Monitor:** DDA2	5/24/13 and Ongoing
			PAT E Houses will monitor on a weekly basis to ensure food products are appropriately labeled, identified and dated. **Tools:** Checklist **Person responsible:** ACM **Monitor:** DDA2	5/24/13 and Ongoing
			All items identified as safety hazards were discarded and/or repaired. **Person responsible:** ACM **Monitor:** DDA2	Completed 5/24/13
			An environmental observation will be completed monthly to identify safety hazards. A work request will be submitted to repair and/or discard safety hazards. **Tools:** Environmental checklist **Person responsible:** ACM **Monitor:** DDA2	5/24/13 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 104	Continued From page 2 1. El Pato Salsa (2 bottles), date received label, no open date 2. Smuckers Grape Jelly, date received label, no open date 3. ½ gallon Milk (2), date received label, no open date 4. Rejuv Prune Juice, date received label, no open date 5. Spaghetti (yellow plastic container), no open date 6. Grand Parmesan, date received label, no open date 7. Spaghetti in foil covered bowel, no open dat 8. Diet Mt. Dew, open, unlabeled Kitchen Freezer: 1. Pancakes, date received label, no open date 2. French Toast (5), date received label, no open date 3. 2 slices of lunchmeat in Ziploc bag, no open date 4. Waffles (24); ripped bag, date received label, no open date 5. Ben & Jerry Ice cream, no open date 6. Scandinavian Frozen Vegetables, date receive label, no open date 7. Waffles (3) in Ziploc bag, undated, unlabeled 8. Ice cream bar, unlabeled 9. 1 tall plastic glass with ice on bottom, unlabeled Upright Freezer (locked): 1. Hotdog buns bag (3), no open date 2. Hotdog buns bag (6), no open date Orcas: (Exterior) 1. Bike parts (screws, bolts, axel) on patio	W 104		

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	50G046	A. BUILDING _____ B. WING _____	03/29/2013

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W 104	Continued From page 3 2. Broken office chair on patio 3. Wooden swing with broken slats, protruding rusty screws 4. Basketball pole with broken rim lying on ground 5. Missing/Broken screen from window 6. Tipped over 2 seat bike with bike chain wrapped around red wagon wheel (Interior) Upright Freezer (locked): 1. Shredded Cheddar Cheese (bag not tied shut) 2. Hot Dog Buns (1 package), open, undated Dining Room Table 1. Ketchup bottle, open, undated San Juan: (Interior) Refrigerator: 1. Ketchup (3 bottles), date received label, no open date 2. Smuckers Grape Jelly (2 bottles), date received label, no open date 3. Syrup (2 containers), date received label, no open date 4. Onion (1/2) in Ziploc bag, date received label, no open date Freezer: 1. Sausages (4), torn bag, date received label, no open date 2. Waffles (5) in Ziploc bag, date received label, no open date 3. French Toast (3), torn bag, date received label, no open date Upright Freezer (locked): 1. Corn Dogs, torn bag, no date opened 2. Brown paper sealed bag, not identified, no	W 104		

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W 104	Continued From page 4 date frozen 3. French Fries, date received label, no date opened 4. Shredded cheese, no label, no date frozen 5: Muffins (resident ' s name), no date frozen Kitchen Cupboard: 1. Bread (3/4) loaf, date received label, no open date 2. Giant Hamburger buns (4), date received label, no open date 3. Thick-It (40oz), date received label, no open date 4. Vinegar (Best if used by date 1/22/13) 5. Fred Meyer Decaffeinated Coffee Jar, date received label, no open date. 6. Krusteaz Buttermilk Biscuit Mix (not opened - box dated 3/25/13)	W 104		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure that 2 of 12 expanded sample residents (Resident #13 & #18) had their own electric razors. Failure to have own electric razors prevented residents from completing tasks toward independent grooming. Findings include: Observations on 03/28/13 of Alpine cottage residents ' rooms revealed two residents did not have electric razors to complete their personal	W 137	Client #13 & #18 razors were located in their bedrooms. **Person responsible:** ACM **Monitor:** DDA2 ACM's will check and ensure that all clients that shave have a razor. When razors are broken or lost, ACM's will submit paperwork to replace razors. **Tools:** checklist **Person responsible:** ACM **Monitor:** DDA2	Completed 3/27/13 5/24/13 and Ongoing

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W 137	Continued From page 5 hygiene care. When asked how the residents completed their grooming for the day the staff were unable to locate the electric razors and were unclear if the residents had been shaved that day.	W 137		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews facility failed to obtain written consents prior to implementation of restrictive programs in regards to locking up sharp knives/items and food items in 4 of 8 cottages (Hyak, Orcas, Omak and San Juan). Failure to obtain written consents denied the resident/guardian the opportunity to make informed decisions about facility restrictive programs. Findings include: All observations, record reviews and interviews were between 03/25/13 and 03/29/13 unless otherwise stated. Omak, Orcas, and San Juan: Kitchen Knives Observations, record reviews, and interviews revealed all sharp knives/items were locked up and not accessible for resident use. Interviews on 03/28/13 with the Habilitation Program Administrators (HPA) ' s revealed	W 263	All guardians for PAT E clients will be receiving a written consent letter related to sharp knives being secured. Additionally, HRC will receive the signed letter (when returned by guardian) for review. All guardians for Hyak, Omak, Orcas, and San Juan house clients will be receiving a written consent letter related to locked freezers and/or cabinets. Additionally, HRC will receive the signed letter (when returned by guardian) for review. **Person responsible:** QIDP/DDA1 **Monitor:** DDA2 DDA1 will randomly select four clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that residents/guardian are afforded the opportunity to make informed decisions about facility restrictive programs. **Tools:** DDA1 review form **Person responsible:** DDA1 **Monitor:** DDA2	Completed 3/18/13 4/24/13 5/24/13 and Ongoing

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W 263	Continued From page 6 guardians had been notified of the restrictive practice but the facility had not yet completed the process of obtaining all consents. Hyak, Omak, Orcas, and San Juan: Locked kitchen cupboards and freezers Observation revealed the following: Omak: Locked kitchen cabinet 1. Plastic container filled with creamer packets 2. Diet jelly packets in brown lunch bag 3. Maxwell House coffee packets in paper bag 4. Graham crackers 5. Sanka coffee packets in paper bag 6. Mini-wheat cereal (1.31oz) 7. Pastries (2) 8. Chocolate chips, 4 Ziploc bags 9. Tree Top Fiber Rich Apple Juice (3) 10. Marshmallows 11. Creamer packets in plastic coritainer San Juan Cottage: Locked kitchen cabinet 1. Hershey "s Cocoa 2. Mrs. Dash Seasoning 3. Hershey ' s Syrup 4. Jet Puffed Marshmallow Bits 5. Signature Creamy Peanut Butter 6. Signature Honey 7. Nesqick Chocolate Flavor Hyak Cottage- 1 locked chest freezer, 1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked for staff assistance. Omak Cottage-1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked	W 263		

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W 263	Continued From page 7 for staff assistance. Orcas Cottage- 1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked for staff assistance. San Juan Cottage-1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked for staff assistance. Interviews with facility staff revealed that food items had been locked up in kitchen cupboards and freezers to help with inventory and control for overflow items.	W 263	Resident #1, #10, & #12 physicals have been completed. Person responsible: Clinical Director Monitor: Asst. Superintendent/DDA2	Completed 4/24/13
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record reviews and interviews 3 of 12 sampled residents (Resident #1, 10 and 12) revealed that the Annual Health Care Assessments had not been done within the last year by a physician. Failure to have an Annual Health Care Assessment placed residents at risk of unidentified medical issues which could lead to deterioration in their overall health. Findings include: All record reviews and interviews were conducted on 03/26/13, 03/27/13 and 03/28/13. Resident #1 's file was reviewed and revealed last assessment was completed on 04/22/10. Resident #1 was noted to have the medication [redacted] start on 02/08/13 for [redacted]s. The medication was changed from capsule to liquid form on 02/11/13. Resident #1 started	W 322	All physicals for clients in PAT E have been reviewed for timeliness. Any annual physicals that are overdue will be scheduled/completed. Person responsible: Primary Care Physician Monitor: Clinical Director/DDA1 A tracking log will be developed by 5/24/13 and reviewed monthly by the Clinical Director to ensure all physicals are completed annually. Tools: Tracking log checklist Person responsible: Primary Care Physician Monitor: Clinical Director/DDA1/DDA2	5/24/13 and ongoing 5/24/13 and Ongoing

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W 322	Continued From page 8 having falls on 02/11/13 through 03/26/13 (at time of review). Review of resident ' s file noted that resident had one fall in December, one fall in January, two falls in February, and eight falls in March with the two falls in February and the eight in March coming after the start of the new medication. No physician assessment had been done to determine if the medication was or was not helping the resident ' s mobility. Resident #10 ' s file revealed last Annual Health Care Assessment was completed on 10/16/2011. Resident #12 ' s file revealed last Annual Health Care Assessment was completed on 07/18/2011.	W 322		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews 7 of 12 sampled residents (Resident #1, 6, 7, 8, 9, 11 and 12) had not received annual/or as recommended audiology exams. Failure to provide a timely audiology exam placed residents at risk of unidentified changes in hearing and/or other medical issues which could lead to deterioration in their overall health. Findings include: All document reviews and interviews were conducted between 03/25/13 and 03/29/13 unless otherwise stated. Record review revealed that Resident #1 ' s last hearing evaluation was completed in 2008 with a recommended follow-up in three years.	W 323	Resident #1, #6, 7, 8, 9, &11 based on assessed need will be referred to an Audiologist. **Person responsible:** Clinical Director **Monitor:** Asst. Superintendent/DDA2 All PAT E clients have been reviewed/ assessed by a physician related to their hearing during 90 day review. Any client with an assessed need will be referred to an Audiologist. **Person responsible:** Primary Care Physician **Monitor:** Clinical Director	5/24/13 and ongoing 5/24/13 and ongoing

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W 323	Continued From page 9 Record review revealed that Resident #6 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #7 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #8 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #9 ' s last hearing evaluation was completed in 2011 with a recommended follow up in six months due to significant changes with his hearing ability. Record review revealed that Resident #11 ' s last hearing evaluation was completed in 2008 with a recommended follow-up in three years. Record review revealed that Resident #12 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Interview with the RN4 revealed the facility does not have an audiologist at this time.	W 323		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD Is not met as evidenced by: Based on interviews and record reviews facility	W 336		

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W 336	Continued From page 10 failed to complete Quarterly Nursing Assessments for 1 of 1 sampled residents (Resident #9) and 14 of 15 expanded sample residents (Resident #34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, 48). Failure to complete Quarterly Nursing Assessments placed residents at risk for unmet nursing care needs. Findings include: All interviews and record reviews were completed between 03/25/13 and 03/29/13. Record reviews revealed Quarterly Nursing Assessments had not been done. Resident #9 had a quarterly nursing assessment completed in 02/2013, however he had not had quarterly nursing assessment performed in 2012. Resident #34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, 48 had quarterly nursing assessments completed in 02/2013, however had not had a Quarterly Nursing Assessments performed in 2012. Resident #34 had a Quarterly Nursing Assessment completed in 01/2013, however had not had a Quarterly Nursing Assessments performed in 2012. Interviews with nursing staff revealed the facility had failed to provide Quarterly Nursing Assessments for residents of San Juan cottage during 2012.	W 336	Involved nursing staff received corrective action and retrained in the following: Review of the Nursing Process Quarterly Review section with the emphasis on completion, documentation and filing a direct physical exam in conjunction with the Nursing Quarterly Review. Residents #9, 34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, & 48 will have direct physical exams completed, and documented and filed. All RN staff with Primary Care Nurse duties trained to complete, document and file a direct physical exam in conjunction with the Nursing Quarterly Review. This training will be reviewed/retaught annually. Training for new PCNs will be completed during the Nursing Orientation process. Nurse Managers will review/monitor for timely completion on a regular basis. **Tools:** Checklist **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2	Completed 2/15/13 Completed 2/15/13 Completed 2/25/13 Within 30 days of hire Completed 2/28/13 and ongoing
W 337	483.460(c)(3)(iv) NURSING SERVICES Nursing services must include, for those clients	W 337		

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W 337	Continued From page 11 certified as not needing a medical care plan, a review of their health status which must be recorded in the client's record. This STANDARD is not met as evidenced by: Based on record review 3 of 12 sample residents (Resident #1, 10, and 11) revealed documentation ordered by a physician was not completed on resident treatment sheets. Failure to document provided an inaccurate account of residents' medical condition. Findings include: Resident #1 has an order for "BM (Bowel Movement) monitoring, every shift, if no BM for 3 days, give prn [1] as ordered on MAR (Medication Administration Record)." Resident #1's IHP (Individual Habilitation Plan) states that resident continues to have multiple instances of abdominal distention, constipation and is on an extensive bowel program including: [3] and Simethicone for gas. He also receives a [3] suppository as needed. Resident has several days with little or no bowel movements followed by episodes of diarrhea. He had an increase in agitation and threats of aggression towards staff. Documentation was missing on the following dates: • February 2013 - Day shift: Feb. 16 & 28 Night shift: all month • January 2013 - Day shift: Jan. 17, 18, & 25 Evening shift: Jan. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 21, & 23 Night shift: all month • December 2012 - Day shift: Dec. 1, 2, 3, 5, 9, 10, 16, 20, 21, 22, 25, 27, & 29	W 337	3. PCNs will complete a QA monitoring sheet for ALL discrepancies regarding completion/documentation of lack of specified data and sent to the nurse manager for that area. For all AC nursing orders with discrepancies, send an email to the ACM, noting that date on the QA monitoring form and submit to the nurse manager for that area. All new nursing staff will be trained within 45 days of hire. All nursing staff will be re-trained annually. Monitoring/reviewing for completion will be done on a regular basis. **Tools:** Checklist **Responsible:** RN 4 **Monitor:** DON All ACMs will be instructed to monitor nursing orders twice monthly for completion/documentation of specified data. **Tools:** checklist **Responsible:** ACM **Monitor:** DDA2	5/29/13 and ongoing 5/29/13 and ongoing

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W 337	Continued From page 12 Evening shift: Dec. 5, 9, 17, 18, & 27 Night shift: all month Resident #1 has an order for " Bag balm to peri area EVERY AM AND PM to prevent skin breakdown. Wash with warm soapy water prior to applying. " documentation was missing on the following dates: - February 2013 - Day shift: Feb. 16 & 28 - January 2013 - Day shift: Jan. 1, 2, 5, 6, 7, 9, 13, 24, 25, & 31 Evening shift: Jan. 1, 2, 3, 4, 5, 6, & 7 - December 2012 - Day shift: Dec. 1, 2, 4, 5, 7, 9, 12, 13, 14, 16, 22, 25, 27, 29, & 31 Evening shift: Dec. 5 & 27 Resident #10 has an order to " Obtain BP (blood pressure, P (pulse) weekly on Saturday AM. Report Systolic BP >60 or <90, Diastolic BP >100 or <50. Pulse>100 or <60 to RN/MD (Registered Nurse or Medical Doctor)." documentation was missing on the following dates: - February 2013 - Day shift: Feb. 16th Resident #10 has an order to " Inspect and perform fingernail hygiene, as needed, every Saturday AM. Inspect and perform toenail care, as needed, every Saturday PM. " Documentation was missing on the following dates: - February 2013 - Day shift: Feb. 2, 16, & 23 Evening Shift: Feb. 2, 16, & 23 - January 2013 - Day shift: Jan. 5, 12, 19, & 26 Evening shift: Jan. 5, 12, 19, & 26 - December 2012 - Day shift: Dec. 1, 8, 15, 22, & 26 Evening shift: Dec. 1, 8, 15, 22, & 26	W 337	For clients # 1, 10 and 11 PAT E Nurses trained to review/check BM monitoring flow sheet/nursing order AM and PM shift daily. AC staff will be trained in completing Nursing Orders thoroughly to ensure proper medical care is provided. All nursing staff trained to review/check BM monitoring flow sheet/nursing order AM and PM shift daily. All new nurses will be trained within 30 days of hire. All nurses will be re-trained/annually. **Responsible:** RN 4 **Monitor:** DON For client # 10, identified nurse counseled regarding scheduled BP monitoring nursing orders. All nursing staff trained to follow scheduled monitoring of BPs/Nursing Orders. All RNs will be trained in the following: 1. Monitor nursing orders twice monthly for completion/documentation of specified data. 2. PCNs are to review/monitor all nursing orders two times each month, initialing in the appropriate box at the bottom of the page, indicating the date that they reviewed/monitored the nursing orders for completion/ data input.	5/29/2013 5/29/2013 5/29/2013 Completed 4/18/2013 5/29/2013 and ongoing. 5/29/2013 and ongoing

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W 337	Continued From page 13 Resident #11 has an order to " Inspect and perform fingernail hygiene, as needed, every other Saturday AM. Inspect and perform toenail hygiene as needed, every other Saturday PM. " Documentation was missing on the following dates: February 2013 - Feb. 2 (fingernail and toenail) Feb. 9 (toenail) Feb. 16 (fingernail and toenail) Feb. 23 (fingernail and toenail) January 2013 - Jan. 5; 12; 19; & 26 (fingernail and toenail) December 2012 - Dec. 1; 8; 15; & 22 (fingernail and toenail) Resident #11 has an order to " Monitor for BM' s (bowel movements), if no BM in three days notifies nurse. " Documentation was missing on the following dates: February 2013 - Day shift: Feb. 9, 10, & 28 Evening shift: Feb 1, 2, 4, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 26, 27, & 28 January 2013 - Day shift: Jan. 2, 30, & 31 December 2012 - Dayshift: Dec. 1, 2, 3, 6, 8, 9, 10, 13, 15, 16, 19, & 20 Evening shift: Dec. 3, 4, 5, 6, 7, 8, 9, 11, 15, 22, 23, 24, 25, 28, 29, 29, & 31 Night shift: Dec. 31	W 337	Toilet paper was replaced/stocked. **Person responsible:** ACM **Monitor:** DDA2 All PAT E houses will have toilet paper available in all bathrooms. Bathrooms will be checked 2x's per shift and at change of shift for toilet paper and if there is no toilet paper in the dispenser, staff will restock it. **Person responsible:** ACM **Monitor:** DDA2 ACM's will randomly check toilet paper dispensers five times quarterly. If no toilet paper is in the dispenser, ACM will notify staff to restock it. **Person responsible:** ACM **Monitor:** DDA2	Completed 4/24/13 5/24/13 and Ongoing 5/24/13 and Ongoing
W 424	483.470(d)(1) CLIENT BATHROOMS The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients. This STANDARD is not met as evidenced by:	W 424		

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	50G046	A. BUILDING _____ B. WING _____	03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 424	Continued From page 14 Based on observations facility failed to provide toilet paper in 2 of 8 cottages (Omak and San Juan). Failure to provide toilet paper prevented residents from maintaining good hygiene following toileting. The findings include: Omak: Bathroom 1. 03/28/13 09:00 AM -No toilet paper in bathroom(B15) 2. 03/29/13 10:00 AM -No toilet paper in bathroom(B13) San Juan: Bathroom 1. 03/26/13 08:20 AM -No toilet paper in bathroom (A13) 2. 03/26/13 08:20 AM -No toilet paper in bathroom (A15) 3. 03/28/13 2:00 PM -No toilet paper in bathroom (B15)	W 424	Bathrooms have been deep cleaned. A service request and referral to CMO for assessment for Orcas House B15, Omak House B13 & B15.	Completed 4/24/13 Completed 4/24/13
W 454	483.470(I)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations facility failed to provide sanitary bathrooms in 2 of 8 cottages (Omak and Orcas). Failure placed residents at risk of being exposed to unsanitary conditions which could cause health risks. Findings include: Observations at Omak Cottage on 03/25/13, 03/28/13 and 03/29/13 revealed bathroom B13 and B15 having an extremely strong smell of urine. Observations at Orcas Cottage on 03/25/13 and 03/27/2013, revealed bathroom B15 had an	W 454	**Person responsible:** Maintenance **Monitor:** Asst. Superintendent/DDA2 Necessary repairs/corrections will be made per assessment. **Person responsible:** Maintenance **Monitor:** Asst. Superintendent/DDA2	5/24/13 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 454	Continued From page 15 extremely strong smell of urine.	W 454	Residents #12, 28, 29, 30, 31, 32, 33, 20, &78 razors will be individually labeled and stored. New items purchased will be labeled prior to use. **Person responsible:** ACM **Monitor:** DDA2	Completed 4/24/13
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews facility failed to ensure an active program to store, clean, label and separate personal electric razors in 3 of 8 cottages: [redacted] of 2 sampled residents (Resident #12) and 6 of 7 expanded sampled residents (Resident # 28, 29, 30, 31, 32, 33); [redacted] (resident unknown); and [redacted] of 2 expanded sample residents (Resident #20 & 78). This failure placed residents at risk of being exposed to a communicable disease. Findings include: Observation of laundry room in Omak cottage on 03/27/13 revealed electric razors were being recharged and either laying on top of each other or laying on the counter next to the sink. Two of the electric razors were recharging and laying on top of a used, wet coffee filter that still contained coffee grounds. One electric razor was recharging and laying in a puddle of water next to the coffee maker. One electric razor was recharging and laying in spilled coffee on the counter. The electric razors were not labeled with resident names. Interview with staff in Omak on 03/27/2013 confirmed staff would be unable to identify the correct electric razor for the correct resident when	W 455	ACM's will train all staff in proper use (label, clean) and storage of razors to minimize risk of being exposed to communicable disease. **Tools:** Inservice record form **Person responsible:** ACM **Monitor:** DDA2 ACM's will randomly select five client razors quarterly and ensure the razors are labeled, clean, and stored away from water/ separated to minimize risk of clients being exposed to a communicable disease. **Tools:** checklist **Person responsible:** DDA1 **Monitor:** DDA2	5/24/13 and Ongoing as needed 5/24/13 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G045	A. BUILDING _____ B. WING _____	03/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 455	Continued From page 16 electric razors are unlabeled. Upon removing the electric razor heads it was determined that all unlabeled electric razors had been used on residents. Observation of laundry room in San Juan cottage on 03/27/13 revealed one electric razor laying at the back of the sink. The electric razor was not labeled with a resident's name and staff could not identify which resident owned the electric razor. Observation at [redacted] Cottage on 03/27/13 revealed that Resident #21 and 78's electric razors were in the bathroom, in a drawer together. Electric razors were labeled with resident names; however electric razors were stored in the same drawer, allowing cross contamination.	W 455		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews the facility failed to serve food within 15 minutes of removal from a temperature control device or failed to maintain the appropriate food temperature on [redacted] cottage, 2 of 2 sampled residents (Resident #7 and 8) and 14 of 14 expanded sampled residents (Resident #64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, and 77) and [redacted] cottage, 1 of 1 sampled resident (Resident #9) and 15 of 15 expanded sample residents (#34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, and 48). Failure to serve food promptly resulted in residents being served food that had	W 473		

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	50G046	A. BUILDING _____ B. WING _____	03/29/2013

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W 473	Continued From page 17 not been held at the appropriate temperature creating a potential for foodborne illness. Findings include: Observation at Orcas cottage on 03/25/13 revealed luncheon food items had been removed from the kitchen insulated food cart and placed in food warming bowls. The temperature of the food was taken 20 minutes into the serving time and revealed the following: Chicken nuggets 130°, chopped French dip meat item 100°, ground French dip meat item 137°, green beans 121°, and cooled dairy dressing for salad 60°. Two special diets, covered in foil, had been removed from a temperature controlled device and left in the dining area for over 45 minutes before being served to residents. Observation at San Juan cottage on 03/26/13 revealed luncheon food items had been removed from the kitchen insulated food cart and placed in the dining area. The temperature of the food was taken 20 minutes into the serving time and revealed the following: Chicken Fried Steak 120°, corn 115° and the tapioca orange dessert 55°. When these temperatures were pointed out to the AC3 he asked staff to reheat one of the luncheon plates that had just been served to a resident. USDA guidelines recommend food must be reheated to 165 degrees Fahrenheit or above and held above 140 degrees Fahrenheit until served, in order to destroy the bacteria that can cause food borne illness. Cold food items should be held and served at 45 degrees Fahrenheit or cooler.	W 473	PAT E staff will be instructed/trained to serve food within 15 minutes of removal from food cart and/or serving hot food at 140 degrees. Any food that drops below 140 degrees will be reheated in the microwave or oven. Staff will use a thermometer when needed. **Tools:** Inservice record form **Person Responsible** ACM **Monitor** DDA2 ACM will randomly select five meals quarterly and ensure food is served within 15 minutes of removal from food cart, and/or food is served at 140 to 115 degrees. **Tools:** checklist **Person Responsible:** ACM **Monitor:** DDA2	5/24/13 and ongoing 5/24/13 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 478	483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observations and record reviews the facility failed to provide a variety of foods at each meal for 1 of 1 sampled residents (Resident #1) and 7 of 7 expanded sample residents (Resident #48, 66, 67, 69, 72, 76, 78) who receive specialized diets. Failure to provide alternatives did not give residents a choice of foods. Findings include: All observations of meal service were on 03/25/13 through 03/28/13 unless otherwise specified. During the meal service Resident #1, 48, 66, 67, 69, 72, 76 and 78 received their specialized meals from the kitchen. Residents were not offered an alternative to the meal that was being served.	W 478	PAT E staff will be instructed/trained to offer meal alternatives to residents who receive specialized diets. Tools: inservice record form Person Responsible ACM Monitor DDA2 ACM will randomly select five meals quarterly and ensure residents who receive specialized diets receive alternate meal choices. Tools: Checklist Person Responsible: ACM Monitor: DDA2	5/24/13 5/24/13 and Ongoing
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations facility failed to allow residents the opportunity to serve independently at Tyee/Shasta during meal time. Failure placed residents at risk for diminished ability in skill development and potential loss of independence. Findings include: Observation on Tyee/Shasta on 03/25/13 revealed that staff served the food not allowing residents the opportunity to serve self	W 488		

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W 488	Continued From page 19 independently.	W 488	Tyee/Shasta staff will be instructed/trained to assure that each resident eats in a manner consistent with his or her developmental level. **Tools:** Inservice record form **Person Responsible** ACM **Monitor** DDA2	5/24/13 And ongoing
			Pat E staff will be instructed/trained to assure that each resident eats in a manner consistent with his or her developmental level. **Tools:** Inservice record form **Person Responsible** ACM **Monitor** DDA2	5/24/13 And ongoing
			ACM's will randomly select five meals quarterly and ensure residents eat in a manner consistent with his or her developmental level. **Tools:** checklist **Person Responsible:** ACM **Monitor:** DDA2	5/24/13 And ongoing

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ADSA, RCS, ICF/ID Survey & Certification Program
PO Box 45600, Olympia, WA 98504-5600

April 27, 2012
CERTIFIED MAIL (7007 1490 0003 4205 8248)

Neil Crowley, Superintendent
Rainier School PAT E
PO Box 600
Buckley, WA 98321

RE: Annual Recertification Survey
4/11/2012 through 4/17/2012

Dear Mr. Crowley:

From 4/11/2012 through 4/17/2012 ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the recertification survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 60 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC signed and dated to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, Quality Assurance Administrator
ICF/ID Survey and Certification Program

Residential Care Services, **Mail Stop: 45600**
PO Box 45600
Olympia, WA 98504-5600
Office (360) 725-2419 Fax (360) 725-3208

RCS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at (360)725-2419.

Sincerely,

Robert McClintock, QA Administrator
ICF/ID Survey and Certification Program
Residential Care Services

Enclosures

cc: Janet Adams, DDD
ICF/ID File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	04/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 000	INITIAL COMMENTS This report is a result of the annual recertification survey conducted at Rainier School Pat E on 4/11/12, 4/12/12, 4/13/12, 4/16/12 and 4/17/12 . The survey was conducted by: Kathy Heinz Janette Buchanan Terry Patton Mark White The surveyors are from: Residential Care Services ICF/ID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600	W 000	The Orcas IDT assessed client #4 needs and personal possessions belonging to client #4 were unsecured. The Hyak IDT assessed client #13 & #14 needs and submitted a Service Care Plan (SCP) which included a risk/benefit analysis related to locking the personal property. The SCP has been submitted HRC for review and approval for those restrictions identified in the SCP. **Person responsible:** QIDP/DDA1 **Monitor:** DDA2	Completed
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility violated resident rights by failing to insure one of twelve sample residents and two of two expanded sample had appropriate access to their property. Findings include: Observation on 4/ 16/12 at [redacted] house revealed Resident #6 asked staff #1 for a pop. Staff #1 unlocked the house manager ' s office door and	W 125	PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions have risk/benefit analysis and HRC approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc/SCP with risk/benefit analysis will be submitted to HRC for review and approval for those restrictions identified in the Ad-hoc/SCP. **Person responsible:** QIDP/DDA1 **Monitor:** DDA2 DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected and provided due process. **Person responsible:** DDA1 **Monitor:** DDA2	6/04/12 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sept. 5/7/12

* deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	04/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

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W 125	Continued From page 1 then unlocked a closet door in the manager office. Staff #1 handed Resident #6 a soda that belonged to Resident #14. Soda belonging to resident #13 was also observed in the locked closet. Store receipts revealed Resident #13 and #14 purchased the soda with their own money. Staff #1 stated resident #14 ' s soda was locked in the closet because Resident #14 would drink all of his soda. Staff #2 stated that resident #14 would also drink all of his soda if he was allowed to keep it in his room. Resident #4 ' s eyeglasses were locked in a cabinet in the living room at [redacted] House. Resident #4 did not have a key to this cabinet and could not wear his own glasses unless staff chose to unlock the cabinet. The facility had no documentation of the reasons for these property restrictions or the process by which the restrictions were authorized and created.	W 125		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to insure the human rights committee reviewed and approved restrictive procedures the facility was implementing for one of twelve and two of two expanded sample Residents. Failure of the facility to insure the human rights	W 262		

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W 262	Continued From page 2 committee reviewed and approved restrictive procedures prevented the committee from determining if the restrictions were warranted. Findings include: Store receipts dated 4/4/12 and 4/11/12 revealed Resident #13 and #14 purchased soda with their own money. The soda was then locked in a closet located in a locked office. Residents #13 and #14 did not have keys to the office or the closet. The human rights committee had not approved the restriction the facility had implemented to control the amount of soda Resident #13 and #14 consumed. Eyeglasses belonging to Resident #4 were kept locked in a cabinet in the living room at [redacted] House where Resident #4 could not access them unless staff opened the cabinet for him. The Facility's Human Rights Committee had not reviewed and approved this restrictive procedure.	W 262	The [redacted] IDT assessed client #4 needs and personal possessions belonging of client #4 were unsecured. The [redacted] IDT assessed client #13 & #14 needs and submitted a Service Care Plan (SCP) which included a risk/benefit analysis related to locking the personal property. The SCP has been submitted HRC for review and approval for those restrictions identified in the SCP. **Person responsible:** QIDP/DDA1 **Monitor:** DDA2	Completed
			PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions have risk/benefit analysis and HRC approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc/SCP with risk/benefit analysis will be submitted to HRC for review and approval for those restrictions identified in the Ad-hoc/SCP. **Person responsible:** QIDP/DDA1 **Monitor:** DDA2	6/04/12
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and on interview the facility failed to insure guardians consented to restrictive procedures that had been implemented by the facility for one of twelve sample residents and two of two expanded sample residents. Failure of the facility to obtain guardian approval for restrictive procedures jeopardized the rights of vulnerable residents. Findings include: Store receipts dated 4/4/12 and 4/11/12	W 263	DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected and provided due process. **Person responsible:** DDA1 **Monitor:** DDA2	Ongoing

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W 263	Continued From page 3 revealed resident #13 and #14 purchased soda with their own money. The soda was then locked in a closet located in a locked office. Residents #13 and #14 did not have keys to the office or the closet. There were no written consents from the guardians allowing the facility to lock up the soda that was purchased by the Residents. Eyeglasses belonging to Resident #4 were kept locked in a cabinet in the living room at [redacted] House where Resident #4 could not access them unless staff opened the cabinet for him. Resident #4 ' s guardian had not reviewed and approved this restrictive procedure.	W 263	The [redacted] IDT assessed client #4 needs and personal possessions belonging of client #4 were unsecured. The [redacted] IDT assessed client #13 & #14 needs and submitted a Service Care Plan (SCP) which included a risk/benefit analysis related to locking the personal property. The SCP has been submitted HRC and client/parent/guardian for review and approval for those restrictions identified in the SCP. Person responsible: QIDP/DDA1 Monitor: DDA2 PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions have risk/benefit analysis, HRC and client/parent/guardian approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc/SCP with risk/benefit analysis will be submitted to HRC for review, and client/parent/guardian for approval of those restrictions identified in the Ad-hoc/SCP. Person responsible: QIDP/DDA1 Monitor: DDA2 DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected, provided due process, and written informed consent is obtained prior to securing client possessions. Person responsible: DDA1 Monitor: DDA2	Complete 6/04/12 Ongoing

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

April 4, 2011
Certified Mail (7009 3410 0001 8069 8725)

Neil Crowley, Superintendent
Rainier School - PAT E
P O Box 600
Buckley, WA 98321

RE: Recertification Survey 03/22/2011-03/29/2011

Dear Superintendent:

From 3/22/2011 through 3/29/2011 ICF/ID survey staff from the Residential Care Services (RCS) Division of Aging and Disability Services Administration (ADSA) conducted a recertification survey at your facility to determine compliance with Federal requirements for ICF/ID facilities participating in the Medicaid program. The CMS 2567 Statement of Deficiencies for the survey is enclosed.

Plan of Correction (POC)

You must detail a POC on the enclosed original CMS 2567 form for all deficiencies. Your POC must at minimum address each of the bulleted items below.

- How the facility will correct the deficiency as it relates to the resident;
- How the facility will act to protect residents in similar situations;
- Measures the facility will take or the systems it will alter to ensure that the problem does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained;
- Dates when corrective action will be completed (no more than 45 days from the last day of the inspection); and
- The title of the person or persons responsible to ensure correction for each deficiency.

You must also send the original 2567 form with your POC to the Manager below no later than 10 calendar days after you receive this letter. Failure to submit an acceptable POC by the 10th calendar day may result in the imposition of remedies.

Robert McClintock, QA Administrator
ICF/MR Survey and Certification Program
Residential Care Services, Mail Stop: N27-23
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

DSHS will use the POC as a part of the basis for verifying whether the deficiencies have been corrected. If you modify your POC after submission, you must immediately notify the above office in writing. Any POC modification must address each "W" tag number with related details about any modifications.

Informal Dispute Resolution (IDR)

You have an opportunity to question cited deficiencies and/or state actions initiated in response to them, through the state's informal review and dispute resolution process. Unless you become entitled to a federal administrative hearing following imposition of a federal remedy, this will be your only opportunity to challenge the deficiencies described on CMS Form 2567.

To request an informal dispute resolution (IDR) meeting, please send your written request to Robert McClintock, QA Administrator, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a POC within the time limits described above. The written IDR request should:

- Identify the specific deficiencies that are disputed;
- Explain why you are disputing the deficiencies;
- Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review);and
- Be sent during the same 10 calendar days you have for submitting a POC for the cited deficiencies.

During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. An incomplete review and dispute resolution process will not delay the effective date of any enforcement action.

If you have any questions concerning the instructions contained in this letter, please contact me at 360.725.2419.

Sincerely,

for Robert McClintock, QA Administrator
ICF/MR Survey and Certification Program
Residential Care Services

Enclosures
cc: Janet Adams, DDD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	03/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SCHOOL PAT E	RYAN ROAD BUCKLEY, WA 98321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This report is a result of an Annual Recertification Survey conducted at Rainier School - PAT E from 3/22/11 through 3/29/11 completed by Gerald Heilinger, Kathy Heinz, Terry Patton and Mark White from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street, MS: N27-23 Tacoma, WA 98405-2850 Office Phone: (253) 476-7171 FAX: (253) 593-2809 Revised on June 20, 2011	W 000		
149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: 1. Based on observation, record review and interviews, it was determined the facility failed to insure Resident #10 's plan of supervision was carried out following an incident where Resident #10 attempted to sexually assault a female peer (Expanded Sample Resident #21). Resident #10 was to have line of sight supervision when in his home, and a State Agency surveyor observed him in his home with no staff present to watch him. Failure to insure Resident #10 was under constant supervision placed other Residents at risk of being sexually assaulted. Findings include:	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

...iency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...eguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days foll... the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 Review on 3/22/11 of a facility investigation dated 3/4/11 revealed Resident #10 was masturbating in the common area of his home. Staff #1 directed Resident #10 to leave the common area of the home. Resident #10 left the area and entered a bathroom occupied by a female peer (#21) who had just finished showering and was naked Staff #2 discovered Resident #10 grabbing the arm of Resident #21 with one hand, holding his erect penis in the other and trying to push himself into her. Review of an interdisciplinary note completed by a qualified mental retardation professional dated 3/4/11 and an AD HOC dated 3/8/11 that was held as a result of the incident, revealed staff were to provide line of sight supervision for Resident #10 while he is in common areas of his home. Observation by a surveyor on 3/25/11 at [redacted] house at 2 pm, revealed Resident #10 sitting in a common area of the home. There were no staff present. Interview with the Attendant Counselor 3 at 2:05 pm revealed she had left the common area where Resident #10 was sitting to talk with a maintenance worker. 2. Based on observation, record review and interviews, it was determined the facility failed to insure nurses and direct care staff followed the facility ' s Medication Administration Procedure, when expanded sample Resident #14 received expanded sample Resident #15 ' s [redacted] Failure of the facility to insure nurses and direct care staff follow the medication administration procedure resulted in Resident #14 receiving the wrong medication which could lead to medical complications and serious harm. Findings include: Review on 3/23/11 of the Incident Report dated	W 149	1. Employee who failed to follow #10 resident plan of supervision was given correction action. 2. Employees involved who failed to follow the facility's Medication Administration Procedure were given corrective action. **Person responsible:** DDA2/RN Manager **Monitor:** DDA2/Nursing Director	Completed
			1. PAT E employees will be trained on the different types/levels of resident supervision. 2. Nursing will review/modify resident identification procedures for residents who receive [redacted] medication. **Person responsible:** ACM's/DDA1/RN Manager **Monitor:** Nursing Director/DDA2	5/30/11
			1. DDA1 will complete five observations per quarter to ensure that staff are following plans of supervision for clients who require above average level of supervision to protect health/safety. ACM/DDA1 will provide training and/or corrective action as needed. 2. RN Manager will complete five observations per quarter to ensure that nursing personnel are following facility Medication Administration Procedures. RN Manager will provide training and/or corrective action as needed. **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2	Ongoing

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W 149	Continued From page 2 3/21/11 revealed that at 7:10 pm on 3/21/11 a Licensed Practical Nurse administered [redacted] 325 mg., [redacted] 0.5 mg, [redacted] 150 mg., and [redacted] 600mg. tablets to Expanded Sample Resident #14 . These medications were not ordered for Resident #14. The medications had been ordered for Expanded Sample Resident #15. Review on 3/24/11 of the facility ' s Medication Administration Procedure shows that direct care staff are required to bring all Residents receiving medications to the medication cart and identify the Resident to the nurse. Then the nurse must also identify the Residents by their picture before the medications may be administered. In addition, if the Resident is receiving [redacted] the staff is required to initial on the Resident ' s Medication Administration Record (MAR) that the correct Resident received the [redacted] The Incident Report shows a staff verbally identified Resident #14 to the nurse. The nurse gave Resident #15 ' s medications to Resident #14 without comparing a picture of the Resident to the actual resident. The nurse asked the staff to initial the MAR for Resident #15 verifying that Resident #15 received the [redacted] The direct care staff reports she initialed the MAR without looking at the name of the Resident. Interview on 3/24/11 with the Registered Nurse 4 confirmed Resident #14 was sent to a hospital for evaluation and treatment due to the potential serious harm which may have resulted from the administration of these medications, particularly the [redacted]	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	W 153		

STATEMENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 153	Continued From page 3 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on review of the facility's system to prevent abuse neglect and mistreatment (Task 2) and interview verification, it was determined the facility failed to report two incidents of sexual abuse to the Complaint Resolution Unit (CRU). In one incident, Resident #10 was attempting to sexually penetrate a female peer as she stood naked in the bathroom. In the second incident, Resident #20 was found with his hands in the pants of his roommate as his roommate was lying in bed. The facility did not report these incidents because their Incident Management Map, which is part of their incident management system indicated they did not need to be reported. However, sexual incidents of this nature could involve abuse, neglect or mistreatment and must be reported. Failure of the facility to see sexual incidents as having potential abuse, neglect or mistreatment involved caused them to not report the incidents to the CRU. This failure also prevents the State Agency from reviewing the incidents and determining if the facility took adequate corrective and protective measures. Findings include: 1. Review on 3/22/11 of a facility investigation dated 3/4/11 revealed Resident #10 was masturbating in the common area of his home. Staff #1 directed Resident #10 to leave the common area of the home. Resident #10 left the area and entered a bathroom occupied by a	W 153	The Complaint Resolution Unit (CRU) was notified of the two incidents of unwanted sexual touch dated 3/4/11 and 5/19/10. **Person responsible:** ACM **Monitor:** DDA2 Rainier School will review DDD policy 5.13 and modify Rainier School Incident Management map to ensure it indicates that all incidents of unwanted sexual touch are reported to CRU. **Person responsible:** Incident Coordinator/ACM **Monitor:** DDA2 ACM//DDA1/DDA2 will review incident reports to ensure incidents of unwanted sexual touch are reported timely to CRU and provide training and/or corrective action as needed. **Person responsible:** DDA2 **Monitor:** Asst. Superintendent	Completed 6/30/11 Ongoing

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W 153	Continued From page 4 female peer (#21) who had just finished showering and was naked. Staff #2 discovered Resident #10 grabbing the arm of Resident #21 with one hand, holding his erect penis in the other, and trying to penetrate her sexually. There was no indication on the incident report that the incident had been reported to CRU. Interview on 3/29/11 with the facility ' s Incident Coordinator confirmed the incident had not been reported to the CRU. 2. Review on 3/23/11 of a facility Incident Report/Investigation dated 5/19/10 revealed expanded sample Resident #20 was found with his hand inside of the front of expanded sample Resident #19 ' s pants and underwear. Resident #19 was lying in bed at the time. Staff reported that Resident #19 appeared to be upset, got out of his bed and left the room. There was no indication in the Incident Report that this incident had been reported to CRU. Interview on 3/29/11 with the facility ' s Incident Coordinator confirmed the incident had not been reported to the CRU. Review on 3/24/11 of the facility ' s Incident Management Map (version 2) dated 5/30/08 revealed incidents involving " unwanted sexual contact other than assaultive penetration between persons, one of which is unwilling or incapable of providing informed consent, " are categorized as client to client indecent liberties and do not need to be reported to the CRU. Interview with administrative staff on 3/24/11 verified they do not report incidents that are categorized as indecent liberties to the CRU.	W 153		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189		

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W 189	Continued From page 5 efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, it was determined two facility nurses failed to follow the facility ' s procedure for transporting controlled drugs from one area of the facility to another. In each case staff appeared to be unaware of the facility procedure for transporting controlled drugs. Failure to assure staff are aware of and following the facility ' s procedures related to transporting controlled drugs could result in drugs being lost in areas where they may be found by Residents. Findings include: On 3/23/11 at 4:00 pm Nurse 1 was observed at Tyee House removing medications from her pocket and placing the medications in the medication cart. Nurse 1 explained these were controlled drugs which she had signed out in the Nursing Office and carried to the house in her pocket for administration to Expanded Sample Residents #16, #17, and #18. Review of the Controlled Medication Dispensing Record showed Nurse 1 had received these controlled drugs from the PAT-E Nursing Office: 3 [redacted]1 mg. tablet for Resident #16, 3 [redacted]50 mg. tablet for Resident #17, and a 3 [redacted]37.5/325 mg. Acetaminophen tablet for Resident #18. On 3/24/11 at 8:00 am Nurse 2 was observed administering medications to Residents. He stated he carried the controlled drugs for the Residents from the Nursing Office to the houses using a small black bag with a zipper along the edge which he had attached to his belt. Nurse 2 stated the black bag was a Diastat case.	W 189	Employees involved who failed to follow facility procedures regarding transporting controlled drugs from on area to another were given corrective action. Rainer School will review/update Medication Procedure regarding transporting of controlled drugs. **Person responsible:** Nursing Director **Monitor:** Nursing Director/DDA2 All nurses will be trained on revised Medication Administration procedure regarding transporting of controlled drugs. **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2 RN Manager will complete five observations per quarter to ensure that nursing personnel are following nursing policies regarding transporting controlled drugs. RN Manager will provide training and/or correction action as needed. **Person responsible:** RN Manager **Monitor:** Nursing DirectorDDA2	Completed 5/31/11 Ongoing

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W 189	Continued From page 6 The facility Medication Administration Procedure shows controlled drugs are to be carried from the Nursing Office to the house by the medication nurse in a " secured carrying device " and a Diastat case should not be used. The Registered Nurse 4 stated medication nurses are not to carry controlled drugs in their pockets and they are to use secured devices to carry the controlled drugs. On 3/30/11 the Acting Director of Nursing confirmed the facility procedure prohibits use of a Diastat case to carry controlled drugs.	W 189	Residents #2,3,5,6,7,11,&13 are scheduled for physicals and healthcare assessments will be completed. **Person responsible:** PAT E Doctor **Monitor:** Clinical Director	5/30/11
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to insure the Physician completed annual healthcare assessments for 7 of 13 Sample Residents (#2, 3, 5, 6, 7, 11 & 13). Failure to have annual health care assessments prevents the facility from insuring Residents ' health needs are tracked over time and they receive needed care. Findings include: 1. Review on 3/25/11 of Resident #2 ' s habilitation file revealed the most current annual health care assessment available was dated 5/4/09. Interview on 3/25/11 with the Program Area Team (PAT) Director verified there was no more current assessment. 2. Review on 3/25/11 of Resident #3 ' s habilitation file revealed the most current annual health care assessment available was dated 8/17/09. Interview on 3/25/11 with the PAT	W 322	All physicals and healthcare assessments for clients in PAT E have been reviewed for timeliness. Any annual physicals that are overdue will be scheduled/completed. **Person responsible:** PAT E Doctor **Monitor:** Clinical Director/DDA1 All current healthcare assessments for clients in PAT E will be completed and available for IDT review no less than 14 days prior to the scheduled IHP meeting. **Person responsible:** PAT E Doctor **Monitor:** Clinical Director/DDA1/DDA2	8/31/11 Ongoing

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W 322	Continued From page 7 Director verified there was no more current assessment. 3. Review on 3/25/11 of Resident #5 ' s habilitation file revealed the most current annual health care assessment available was dated 3/22/10. Interview on 3/25/11 with the PAT Director verified there was no more current assessment. 4. Review on 3/25/11 of Resident #6 ' s habilitation file revealed the most current annual health care assessment available was dated 6/17/09. Interview on 3/25/11 with the PAT Director verified there was no more current assessment. 5. Review on 3/25/11 of Resident #7 ' s habilitation file revealed the most current annual health care assessment available was dated 2/12/10. Interview on 3/25/11 with the Habilitation Plan Administrator (HPA) verified there was no more current assessment. 6. Review on 3/25/11 of Resident #11 ' s habilitation file revealed the most current annual health care assessment available was dated 4/27/09. Interview on 3/25/11 with the HPA verified there was no more current assessment. 7. Review on 3/25/11 of Resident #13 ' s habilitation file revealed the most current annual health care assessment available was dated 8/17/09. Interview on 3/25/11 with the PAT Director verified there was no more current assessment.	W 322		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

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W 368	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that medications administered to Expanded Sample Residents 14, 22, 23, 24, and 25 were not given as ordered by the Physician. Failure to administer medications as ordered by the Physician could result in serious harm or death. Findings include: Review on 3/23/11 of the Incident Report dated 1/7/11 revealed that Expanded Sample Resident 25 received 18 doses of [redacted] with Acetaminophen between 11/25/10 and 12/2/10. The Physician ' s Order dated 11/25/10 is for [redacted] and does not include Acetaminophen. On 3/24/11 the Registered Nurse 4 confirmed 5 nurses had given Resident 25 the wrong medication. Review on 3/23/11 of the Incident Report dated 2/9/11 revealed that Expanded Sample Resident 22 did not receive the medications ordered for 8:00 pm on 2/8/11. Those medications not given as ordered were [redacted] 200 mg., [redacted] 500 mg., Acetaminophen 650 mg.,. [redacted] The Registered Nurse 4 confirmed that the medication nurse had removed the medications from their packaging, placed the unlabeled medications in a medication cup, then put the medication cup in a drawer in the medication cart. The medication nurse did not give the medications and they were found in the medication cart the next morning by another nurse. Review on 3/23/11 of the Incident Report dated 2/9/11 revealed that Expanded Sample Resident 23 did not receive the medications ordered for 8:00 pm on 2/8/11. Those medications not given as ordered were Calcium Carbonate and Simethicone. The Registered Nurse 4 confirmed	W 368	Employees involved who failed to administer medications as ordered by the physician were given corrective action. **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2 Discussion at RN/LPN Professional Practice Group meeting with regards to following physicians orders and accuracy during medication administration. **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2 RN Manager will complete five observations per quarter to ensure that nursing personnel are following administering of medication as ordered by the physician. RN Manager will provide training and/or correction action as needed. **Person responsible:** RN Manager **Monitor:** Nursing Director/DDA2	Completed 5/30/11 Ongoing

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W 368	Continued From page 9 that the medication nurse had removed the medications from their packaging, placed the unlabeled medications in a medication cup, then put the medication cup in a drawer in the medication cart. The medication nurse did not give the medications and they were found in the medication cart the next morning by another nurse. Review on 3/23/11 of the Incident Report dated 3/10/11 revealed two nurses administered medications to Expanded Sample Resident 24 without using the Medication Administration Record at 8:00 pm on 3/1/11 and 3/2/11 and 08:00 on 3/1/11. The Registered Nurse 4 confirmed that 2 nurses administered medications to Resident 24 by memory and did not use the Medication Administration Record. Review on 3/23/11 of the Incident Report dated 3/21/11 revealed that at 19:10 on 3/21/11 a Licensed Practical Nurse administered [redacted] 325 mg, [redacted] 0.5 mg, [redacted] 150 mg, and [redacted] 600mg to Expanded Sample Resident 14. The Medication Administration Record shows these medications were not ordered for Resident 14. On 3/24/11 the Registered Nurse 4 confirmed that Resident 14 had been given the wrong medications.	W 368	Aspen House flooring in the service hallway has been assessed for repairs necessary that promote maintenance of sanitary conditions. **Person responsible:** QA Manager **Monitor:** DDA2	Completed
			Rainier School will replace/repair Aspen house service hallway flooring. **Person responsible:** QA Manager **Monitor:** DDA2	5/15/11
V 434	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions. This STANDARD is not met as evidenced by: Based on observations, it was determined the facility did not insure that Aspen House floors were in good repair. This failure results in floors	W 434		

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W 434	Continued From page 10 which are a potential tripping hazard for Residents and present problems in keeping the floor sanitary because of the cracks in the tiles. Findings include: Observation on 3/22/11 of the service hallway at Aspen House revealed the floor was in disrepair. The section in front of the laundry room had a hole in the tiles and the tiles were cracked. Another section of the hallway had tiles that were cracked.	W 434		

Aging & Disability Services

ICF2

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
ICF/MR Survey & Certification Program
1949 South State Street, Tacoma, WA 98405 N27-23

April 1, 2010

By Facsimile

Neil Crowley, Superintendent
Rainier School - PAT E
P O Box 600
Buckley, WA 98321

RE: Recertification Survey 03/23/2010-03/29/2010

Dear Mr. Crowley:

Included with this letter you will find the draft CMS 2567 Statement of Deficiencies (SoD) which resulted from a recertification survey completed by Surveyors on 03/29/2010.

Please be advised of your right to review this draft survey and submit any additional information to clarify or dispute the survey team's findings. Your response should be faxed to the ICF/MR Quality Assurance office and arrive no later than two working days after the date the draft was faxed to your facility..

In the event that there is not a dispute with the survey findings, or once any disagreements pertaining to the survey report have been resolved, the SoD will be considered final and the Plan of Correction (PoC) will be due within ten calendar days of receipt of the final SoD.

In order to meet the ten day timeline, you may write the PoC onto the faxed copy of the SoD for review by the ICF/MR survey team and fax it back to this office, signed and dated, to:

Residential Care Services, **Mail Stop: N27-23**
1949 S. State Street
Tacoma, WA 98405
Office (253) 476-7171 Fax (253) 593-2809

After review of the PoC by ICF/MR team, the original SoD will then be mailed to your facility in order to add the acceptable PoC. A copy of the guidelines for an acceptable PoC is included with this fax.

Thank you for your attention to this matter.

Sincerely,

Tom Farrow, Field Manager
ICF/MR Survey and Certification Program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G046	A. BUILDING _____ B. WING _____	03/29/2010

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W 000	INITIAL COMMENTS This report is the result of the annual Recertification Survey conducted at Rainier School PAT E from 3/23/2010 through 3/29/2010 completed by #12564, #19986, #21833, and #12891 from: D.S.H.S. Aging and Disability Services Administration ICF/MR Survey and Certification Program 1949 South State Street Tacom, WA 98405-2850 MS: N27-23 Office phone: (253) 476-7171 FAX: (253) 593-2809	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview verification, it was determined the facility failed to insure that all houses where Residents lived were clean, in good repair and free from potential hazards. Shasta House had food in the refrigerator and freezer that was not covered, moldy or not dated. Staff took dishes out of the sanitizer that were wet and stacked them up in the cupboard. The walls around the trash can had food on them. The heating system vents were dusty. The ceiling tiles in the dining room were in disrepair. Findings include: Observations on 3/23/10 through 3/25/10 at Shasta House revealed there were holes in the ceiling tiles and air return vents in the dining and living areas were covered with dust. Bowls of food	W 104	Shasta house refrigerator/freezer food was assessed; food that was moldy, uncovered, not sealed, or covered with ice crystals were thrown away. Remaining food was dated. The walls around the trash can were cleaned removing food particles. The heating system vents throughout the house were cleaned. Ceiling tiles in the dining room were repaired. Shasta staff were trained on proper food storage and sanitization of dishes. **Person responsible:** ACM **Monitor:** DDA2 Shasta house ACM will develop a cleaning schedule ensuring house is clean, in good repair and free from potential hazards. All other PAT E have established cleaning schedules to ensure houses are clean, in good repair, and free from potential hazards. **Person responsible:** ACM **Monitor:** DDA2	Completed 5/11/10 Completed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director 5/24/10

...ficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 day following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 were left uncovered in the refrigerator, packages of food were not sealed and one container of food contained moldy salad. Food in the freezer was covered with ice crystals and food no longer in its original package was not dated. A staff and a resident were observed stacking wet cups on a cupboard for future use. The wall behind the kitchen garbage can was covered with food splatters. Interview with direct care staff on 3/24/10 and 3/25/10 verified the above mentioned observations.	W 104	Shasta ACM and/or designee will complete an environmental observation monthly and PAT E RSC will complete an environmental observation quarterly. When areas of concern are identified as unclean, in bad repair, and/or potentially hazardous, work orders will be completed and/or areas cleaned. Shasta house ACM will review cleaning schedules and environmental observations and ensure that all areas of concern are corrected. **Person responsible:** ACM/RSC **Monitor:** DDA2	Ongoing
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined 2 of 2 Residents' (#15 & #16) personal possessions were locked in a cabinet. Residents did not have a key to the cabinet so they had to rely on staff to get access to their possessions. The facility had not done a risk/benefit analysis related to locking the personal property and had not properly abridged their right to have free access to their personal possessions. Findings include: Observation on 3/23/10 at [redacted] House revealed a non-sample Resident trying to open a cupboard containing DVD's and video game equipment. Interview with direct care staff on 3/24/10 revealed the cupboard contained DVD's and video game equipment belonging to Residents	W 125	Personal possessions belonging of #15 & #16 client's were unsecured. The [redacted] IDT assessed client #15 & #16 needs and submitted an Ad-hoc which included a risk/benefit analysis related to locking the personal property. The Ad-hoc has been submitted HRC for review and approval for those restrictions identified in the Ad-hoc. **Person responsible:** QMRP/DDA1 **Monitor:** DDA2 PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions	Completed 6/11/10

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W 125	Continued From page 2 who lived at the home. Review on 3/25/10 of expanded sample Resident #15 and #16's files revealed there were no consents authorizing the facility to lock up their personal possessions. Interview with Administrative staff on 3/25/10 verified there were no consents authorizing the facility to lock up their personal possessions.	W 125	have risk/benefit analysis and HRC approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc with risk/benefit analysis will be submitted to HRC for review and approval for those restrictions identified in the Ad-hoc.	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, interviews and record verification, it was determined the facility failed to develop a training objective for 1 of 8 Sample Residents (Resident #10). Resident #10 was observed to frequently scream in a loud, piercing voice throughout the day. There were no observable consistent reactions by the staff for this behavior. Findings include: Observations of sample Resident #10 at [redacted] House on 3/24/10 from 7:30 to 8:00 am, from 9:15 to 9:30 am, from 11:15 to 11:40 am and on 3/25/10 during breakfast and on the van ride to work revealed she spent the majority of the time screaming. While on the van ride, a non-sample resident stated the screaming "was loud". Interview with Direct Care Staff on 3/24/10 revealed " hat is what she does". Review on 3/25/10 of Resident #10's record revealed there was no Behavior Support Plan. and the Individual Habilitation Plan dated 5/29/10 did not have a specific plan addressing the behavior. Interview	W 227	**Person responsible:** QMRP/DDA1 **Monitor:** DDA2 DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected and provided due process. **Person responsible:** DDA1 **Monitor:** DDA2 Client #10's Comprehensive Functional Assessment will be reviewed and revised based on assessed needs. From the assessed needs, an Ad-hoc addressing a training program has been submitted to HRC for #10 client's screaming behavior. **Person responsible:** IDT/ACM **Monitor:** DDA2	Ongoing Completed

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W 227	Continued From page 3 with administrative staff on 3/25/10 verified there was no specific plan addressing this behavior.	W 227		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to implement training programs for 2 of 13 sample Residents (#3 & #6) and 9 of 9 expanded sample Residents (#17, #18, #19, #20, #21, #22, #23, #24 & #25). Staff did not follow Resident #3's Behavior Support Program (BSP) when she was in her bedroom. Nurses did not follow "Procedure for Client Medication" when they spooned medications into 11 Residents mouths. Findings include: 1. Observations of Sample Resident #3 on 3/24/10 from 10:08 am to 10:38 am and 2:43 pm to 3:13 pm, and on 3/25/10 from 10:00 am to 10:22 am and from 2:00 pm to 2:21 pm revealed she was in her bedroom lying on her bed with a blanket over her. Only on the last observation on 3/25/10 did a staff enter her room, and then they turned the light on (without asking her permission), asked her to join them in the front room (no activity was mentioned) and then left, with the interaction lasting less than a minute.	W 249	All IDT members will receive training in S.O.P. 3:20 regarding Individual Habilitation Plans on assessment of client needs and modification of client programs. **Person responsible:** QMRP/IDT **Monitor:** DDA2 DDA1 will observe five clients for inappropriate behaviors and review client Comprehensive Assessments, IHP's, BSP's per quarter to ensure needs in the CFA are addressed in the IHP/BSP and programs are developed to address the needs. **Person responsible:** DDA1 **Monitor:** DDA2	5/11/10 Ongoing

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W 249	Continued From page 4 Resident #3 stayed in the bedroom. Review on 3/26/10 of Resident #3's Behavior Support Plan (BSP) dated 8/10/09 revealed staff were to offer Resident #3 "the opportunity to join in meaningful activities often (at least every 20 minutes, unless she is already involved in an activity)". An interview with facility administrators verified staff should have been following Resident #3's BSP. 2. Observations on 3/23/10 at [1] house during a medication administration pass for expanded sample Residents #17, #18, #19 and #20, revealed the nurse placed medication into a medication cup with a spoonful of apple sauce. She then scraped the medication and apple sauce onto a spoon and placed the spoon into their mouths. Review on 3/24/10 of Expanded Sample Resident #17 through #20's Comprehensive Functional Assessments (CFA) revealed the Residents were capable of feeding themselves using either a fork or spoon. Review on 3/24/10 of the facility's Procedure for Client Medication dated 1/7/10 revealed there are instructions for nurses "to not spoon feed medications to clients who are able to feed themselves". Interview with the Nurse Manager (Registered Nurse IV) on 3/26/10 verified that the nurses should have followed the facility's procedure and not spoon fed medications to the Resident. 3. Observations on 3/24/10 at [1] house at 3:27 pm revealed the nurse gave medications to Sample Resident #6 and Expanded Sample Residents #22, #23, #24, and #25 by spooning the medications into their mouths as they stood at the medication cart. Observation on 3/25/10 at 11:02 am revealed a nurse gave medications to Residents #24 and #25 by spooning the	W 249	All [1] staff are trained on #3 client's BSP. Nursing staff who administered medications to client's #6, #17, #18, #19, #20, #21, #22, #23, #24, and #35 were counseled on reviewing medication scripts/programs to ensure clients receive appropriate levels of assistance during administration of medication. **Person responsible:** Psychologist/ACM/RN Manager **Monitor:** DDA2 PAT E AC staff will receive training in client BSP's within two weeks of approval/implementation. Nursing staff will receive training to review medication scripts/programs to ensure clients receive appropriate levels of assistance during administration of medication. **Person responsible:** Psychologist/ACM/RN Manager **Monitor:** DDA2 DDA1 and/or designee will randomly select five clients quarterly and observe their IHP/BSP programs, ensuring continuous active treatment programs are implemented correctly. **Person responsible:** DDA1/RN Manager **Monitor:** DDA2	Completed Ongoing 5/11/10 Ongoing

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W 249	Continued From page 5 medications into their mouths as they stood at the medication cart. Record review on 3/25/10 of the Comprehensive Functional Assessments for Sample Resident #6 and Expanded Sample Residents #22, #23, #24, and #25 revealed they were able to use eating utensils spontaneously. Interview with the Nurse Manager (Registered Nurse IV) on 3/26/10 verified that the nurses should have followed the facility's procedure and not spoon fed medications to the Resident. 4. Observation at Shasta house during the morning medication pass on 3/25/10 revealed the nurse spooned expanded sample Resident #21's medications into her mouth. Review on 3/25/10 of the CFA dated 4/21/10 revealed Resident #21 can "take medication independently if given the correct dose". Interview with the Nurse Manager (Registered Nurse IV) on 3/26/10 verified that the nurses should have followed the facility's procedure and not spoon fed medications to the Resident.	W 249	Personal possessions belonging of #15 & #16 client's were unsecured. The [redacted] IDT assessed client #15 & #16 needs and submitted an Ad-hoc which included a risk/benefit analysis related to locking the personal property. The Ad-hoc has been submitted HRC for review and approval for those restrictions identified in the Ad-hoc. **Person responsible:** QMRP/DDA1 **Monitor:** DDA2 PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions have risk/benefit analysis and HRC approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc with risk/benefit analysis will be submitted to HRC for review and approval for those restrictions identified in the Ad-hoc. **Person responsible:** QMRP/DDA1 **Monitor:** DDA2	Completed 6/11/10
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview verification, it was determined the facility failed to obtain consent from the facility Human Rights Committee prior to locking up Residents' personal possessions. At [redacted] House, there	W 262	DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected and provided due process. **Person responsible:** DDA1 **Monitor:** DDA2	Ongoing

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W 262	Continued From page 6 was a cupboard in the living area in which Residents' personal belongings were locked up. Findings Include: Observation at [redacted] House on 3/23/10 revealed a non-sample Resident trying to open a cupboard containing DVD ' s and video game equipment. Interview with direct care staff on 3/24/10 revealed the cupboard contained DVD's and video game equipment belonging to Residents who lived at the home. Review on 3/25/10 of expanded sample Resident #15 and #16's files revealed there were no consents authorizing the facility to lock up their personal possessions. Interview with Administrative staff on 3/25/10 verified there were no consents authorizing the facility to lock up their personal possessions.	W 262	Personal possessions belonging of #15 & #16 client's were unsecured. The [redacted] IDT assessed client #15 & #16 needs and submitted an Ad-hoc which included a risk/benefit analysis related to locking the personal property. The Ad-hoc has been submitted HRC and client/parent/guardian for review and approval for those restrictions identified in the Ad-hoc. **Person responsible:** QMRP/DDA1 **Monitor:** DDA2 PAT E staff will receive training on how to ensure clients have access to personal possessions. If personal possessions are secured, ensure appropriate approvals are obtained. IDT's will complete an environmental check of all PAT E living units for any client secured possessions and ensure that the secured possessions have risk/benefit analysis, HRC and client/parent/guardian approvals. If any additional needs are identified to secure possessions which are not already addressed in the IHP/BSP, an Ad-hoc with risk/benefit analysis will be submitted to HRC for review, and client/parent/guardian for approval of those restrictions identified in the Ad-hoc. **Person responsible:** QMRP/DDA1 **Monitor:** DDA2 DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that client rights are protected, provided due process, and written informed consent is obtained prior to securing client possessions. **Person responsible:** DDA1 **Monitor:** DDA2	Completed 6/11/10 Ongoing
vv 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation , record review and interview verification, it was determined the facility failed to obtain consent from the parents or legal guardian prior to locking up Residents' personal possessions. At [redacted] House there was a cupboard located in the living area in which Residents' personal belongings were locked up. Findings Include: Observation at [redacted] House on 3/23/10 revealed a non-sample Resident trying to open a cupboard containing DVD's and video game	W 263		

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W 263	Continued From page 7 equipment. Interview with direct care staff on 3/24/10 revealed the cupboard contained DVD's and video game equipment belonging to Residents who lived at the home. Review on 3/25/10 of expanded sample Resident #15 and #16's files revealed there were no consents from guardians or parents authorizing the facility to lock up their personal possessions. Interview with Administrative staff on 3/25/10 verified there were no consents authorizing the facility to lock up their personal possessions.	W 263		
W 434	483.470(f)(3) FLOORS The facility must have exposed floor surfaces and floor coverings that promote maintenance of sanitary conditions. This STANDARD is not met as evidenced by: Based on observations and, interviews it was determined the facility failed to ensure the floors of Hyak House were in good repair. The floors on A-side dining room and service areas were pitted, scratched and cracked. Findings include: Observation on 3/24/10 at Hyak House revealed the floor in the service hallway was cracked and in disrepair. The floor in the dining room on the A- side of the house was pitted, scratched and in disrepair. Interview on 3/24/10 with a facility administrator verified the floors were in disrepair.	W 434	Hyak House flooring in the A-side dining room and service hallway has been assessed for repairs necessary that promote maintenance of sanitary conditions. **Person responsible:** QA Manager **Monitor:** DDA2 Rainier School will replace Hyak house A-side dining room and service hallway flooring. Rainier School will work with the Office of Capital Programs to award a contract before August 2010 for flooring repairs or replacement in the A-side dining room and service hallway. The flooring contractor's work will be completed within six months of award of contract. **Person responsible:** QA Manager **Monitor:** DDA2	Completed 9/30/10
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview verification, it was determined the facility failed to conducte a	W 440		

(10)(f)(v) An annotated and detailed list of all responses to findings by the Centers for Medicare and Medicaid Services, and Residential Care Services, specific to audits of the Nursing Facility at Lakeland Village since fiscal year 2010.

- November 7, 2013 Letter from CMS – Re: Compliance with Federal Medicaid Requirements at Lakeland Villages Nursing Facility WA PASRR #1, 11/2013
- January 9, 2015 CMS Letter to HCA Director Dorothy Teeter – Re: 10-FA-2014-WA-01-D & Attached Draft Report
- March 5, 2015 Letter from CMS – Re: Notice of Termination of Medicare Provider Agreement
- March 11, 2015 News Release from Developmental Disabilities Administration (DDA)
- March 16, 2015 Letter from DDA Secretary Evelyn Perez to the Honorable Maralyn Chase.
- May 7, 2015 Letter to Loida Baniqued, Field Manager, Residential Care Services – Re: Credible allegation of compliance, Annual Recertification Survey 3/2/2015 – 3/11/2015
- Citation Summary from the Lakeland Village Nursing Facility Survey of 1/22/2015
- Citation Summary from the Lakeland Village Nursing Facility Survey of 1/27/2015
- List of plan of corrections for Lakeland Village citations
- For additional information on response, see (10)(f)(iv) Lakeland Village

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Seattle Regional Office
2201 Sixth Avenue, Mail Stop 43
Seattle, Washington 98121

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health Operations

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

NOV 07 2013

RE: Compliance with Federal Medicaid Requirements at Lakeland Villages Nursing Facility.
WA PASRR #1, 11/2013

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) is responsible for assuring state compliance with federal statutory and regulatory requirements for states and long term care facilities, as specified in Section 1919 of the Social Security Act (the Act) and 42 CFR Part 483. This letter presents the findings, related disallowance and required corrective actions based on a CMS review of state compliance with those requirements at Lakeland Villages in Medical Lake, a Washington's state-owned and operated long term care facility, specific to 27 residents who were transferred from the Lakeland Village Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) to Lakeland Village nursing facility in 2011. The primary reason for the review was CMS questions about whether Lakeland Village nursing facility is complying with Section 1919 of the Act and with the regulations at 42 CFR Part 483 (Long Term Care Facilities Requirements and Preadmission Screening and Resident Review (PASRR)), whether the 27 transferred residents are in an appropriate setting, whether the residents were transferred to Lakeland nursing facility in violation of federal law, and whether there have been inappropriate claims for federal financial participation (FFP).

The CMS has finished its review of the evidence submitted by the state, including: the records of the 27 Lakeland Village nursing facility residents; correspondence from Disability Rights Washington (DRW); the state's responses to informal staff emails from the CMS Seattle Regional Office (RO) Division of Medicaid and Children's Health Operations (DMCHO) in February, March and April 2013; the state's responses to additional email inquiries from RO management in May and June 2013; and the state's formal written correspondence from Director Cody in May, July and August 2013.

After a review of all evidence and correspondence, we find that Lakeland Village nursing facility is not in compliance with Section 1919 of the Act, is not in compliance with 42 CFR Part 483, that the remaining transferred Lakeland residents are not in an appropriate setting, that the original transfer from the ICF/IID violated federal law, and that as a consequence the state has received FFP in error. The specific CMS findings regarding the transfer of the 27 residents from an ICF/IID to a NF are addressed in attachment 1-A to this letter.

As a consequence of these findings, CMS is:

1. Initiating a disallowance of FFP previously claimed for costs related to the 27 individuals transferred to the Lakeland Village nursing facility in 2011. The notice of disallowance will be separate from and subsequent to this letter.
2. Requiring the state to cease claiming FFP related to the 27 individuals transferred to the Lakeland Village nursing facility in 2011 for nursing facility costs with dates-of-service on and after October 1, 2013.
3. Requiring the state to immediately address and remediate all issues of non-compliance for the surviving 25 individuals transferred in 2011.
4. Requiring the state to take corrective action, and making recommendations designed to bring the state into compliance with Section 1919 of the Act. These actions and recommendations are detailed in attachment 1-B to this letter. Failure to initiate and complete corrective action will result in deferral of additional federal matching funds.
5. Sending a subsequent letter or letters discussing similar concerns related to state compliance with PASRR requirements at all state-owned nursing facilities, including compliance as it applies to additional residents at Lakeland Village nursing facility.

In addition, CMS has notified the Department of Health and Human Services, Office of Civil Rights (OCR) and the CMS Western Consortium Division of Survey and Certification of our review and findings.

If the state believes there is additional information that would mitigate the findings and subsequent actions as specified in this letter and attachments, please contact Cecile Greenway, Manager of the RO10 DMCH Program and Policy Review Branch immediately and provide that additional information to her within 14 days of the date of this letter. Ms. Greenway can be reached via e-mail at cecile.greenway@cms.hhs.gov or by phone at (206) 615-2428.

In addition to this correspondence, CMS will be issuing subsequent letters to address PASRR compliance concerns for the other Lakeland Village nursing facility residents, PASRR compliance concerns at Fircrest School in Seattle and at Yakima Valley School in Selah, as well as regulatory compliance requirements related to discharge and transfer at Lakeland Village ICF. To coordinate these multiple actions, in any correspondence with CMS about the matters discussed in this letter please use the appropriate RE line identifier; in this case "WA PASRR#1, 11/2013."

The CMS is committed to working with the State of Washington, providing technical assistance as needed and providing clarification or discussion as requested in regards to the federal requirements regarding PASRR, our findings in this matter, the subsequent actions, or other information as requested by the State. We look forward to working with you and your staff towards resolving these issues, and assuring the appropriate transfer of and service provision to individuals entering nursing facilities owned by the state of Washington.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Barbara Edwards, DEHPG
Daniel Timmel, DEHPG
Linda Joyce, DEHPG
Ralph Loller, DEHPG
Suzanne Bosstick, DEHPG

FINDINGS

I. Transfers without proper notice. (216 violations)

The physical transfer of a resident from an ICF/IID bed to a nursing facility bed, even one on the same Lakeland campus, is a transfer. 42 CFR 483.12(a)(1)("*Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.*") Likewise, the conversion of a Lakeland cottage/location from ICF/IID certification to nursing facility certification is also a transfer. *Id.*

Federal law requires the transfer of a resident to be accompanied by written notice:

> *(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—*
>
> *(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.*
>
> *(ii) Record the reasons in the resident's clinical record; and*
>
> *(iii) Include in the notice the items described in paragraph (a)(6) of this section. 42 CFR 483.12(a).*

The State provided a form letter dated April 26, 2011 upon which someone had written "*copy sent to all 27.*" We find that none of the clients were provided with the required notice.

Since the letter was not individualized to each client and was not placed in each client's clinical record, the State has failed to document the reason for the transfer. 42 CFR 483.12(a)(3) ("*When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented.*"); 42 CFR 483.12(a)(4)(ii). (54 violations, one for each regulation for each client.)

Since the letter does not contain the reason for the transfer, the letter does not contain the required disclosure of cause. 42 CFR 483.12(a)(4)(i); 42 CFR 483.12(a)(6)(i). (54 violations, one for each regulation for each client.)

Since the letter does not contain the effective date of the transfer, the location to which the resident is being transferred, a statement that the resident has the right to appeal the transfer, or the name, address and telephone number of the State long term care ombudsman, the letter violates 42 CFR 483.12(a)(6)(ii) & (iii) & (iv) & (v). (108 violations, one for each regulation for each client.)

We find that the state transferred the 27 residents without providing them with the required notice.

II. Transfers without Good Cause. (54 violations)

Federal law prohibits the transfer of ICF/IID residents except for six tightly prescribed circumstances:

> *(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—*
>
> *(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;*
>
> *(ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;*
>
> *(iii) The safety of individuals in the facility is endangered;*
>
> *(iv) The health of individuals in the facility would otherwise be endangered;*
>
> *(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or*
>
> *(vi) The facility ceases to operate. 42 CFR 483.12(a)(2)*

In addition, when the transfer is from an ICF, the transfer must also be for good cause:

> *If a client is to be either transferred or discharged, the facility must—*
>
> *(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and*
>
> *(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies). 42 CFR 483.440(b)(4).*

The State explained that transfer of these 27 residents was "*part of DSHS's efforts to reduce expenditures due to state revenue shortfalls.*" (Director Cody letter, May 15, 2013, page 2.) We find that the transfer was primarily motivated by economic concerns and was not based on "*the resident's welfare and the resident's needs.*" 42 CFR 483.12(a)(2). As a general proposition, the State "*must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility*" except in the six specifically identified circumstances. 42 CFR 483.12(a)(2). Transfer for economic reasons is not one of the permissible circumstances. *Id.*

Transfers from an ICF setting must also be for "*good cause.*" 42 CFR 483.440(b)(4)(i).

As is described later, the state failed to provide the 27 transferred residents with the specialized services to which they were entitled from the moment of transfer and continuing thereafter. We find that the state knew or should have known that the only way the transfers from Lakeland ICF/IID would result in any actual cost savings to the state is if the transferred clients were not provided with specialized services in the nursing facility setting; which services would have been extra costs paid by the state through FFS *in addition to* the lower nursing facility rate.

We conclude that the state's revenue shortfalls and economic motivations in this case cannot qualify as good cause for the decision to transfer the 27. The economic savings in these transfers were not achieved by efficiency or lower cost structures, but by withholding Medicaid services to which the residents were entitled. Therefore, we find that the state has violated 42 CFR 483.12(a)(2) and 42 CFR 483.440(b)(4)(i). (54 violations.)

III. Failure to provide specialized services equivalent to "active treatment." (27 violations)

In the case of these 27 transferred residents, each was IID and each was receiving "active treatment" services in the ICF/IID setting prior to transfer. After transfer, absent any significant change in circumstances,[1] each resident would have been entitled to continue to receive specialized services equivalent to the "active treatment" services the residents were receiving previously in the ICF/IID. 42 CFR 483.136(a) (each client with an intellectual disability is to receive a continuous specialized services program which is analogous to the "active treatment" received in an ICF); 42 CFR 483.120(a)(2) (specialized services means the services which meets the requirements of "active treatment" in an ICF). "Active treatment" is a program which includes:

> *[A]ggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—*
>
> *(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and*
>
> *(ii) The prevention or deceleration of regression or loss of current optimal functional status." 42 CFR 483.440(a)(1).*

The state made no argument and presented no evidence that any of the transferred clients had any significant improvement in their cognitive or physical abilities such that the "active treatment" services delivered in the ICF/IID before transfer would not have been necessary after transfer. Thus, each of the 27 transferred residents should have continued to receive, at least initially, a continuous specialized services[2] program, which was analogous to the active treatment provided by Lakeland ICF, in addition

[1] We believe that at least five transferred clients did have a significant change in circumstances due to death (Clients CD and GF) or worsening of physical condition after admission (Clients GS, JS, PC).

[2] Specialized services include, but are not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services. 42 CFR 483.45(a).

to the nursing facility's regular services. 42 CFR 483.120(a)(2); 42 CFR 483.136(a); 42 CFR 483.116(b)(2).

After reviewing the copious treatment records for the 27 transferred residents, we cannot find evidence that any of them actually received specialized services equivalent to the "active treatment" they were receiving before the transfer. Instead, we find each individual's goals and objectives were reduced, and that "active treatment" effectively ceased upon transfer. Accordingly, we find that the state failed to provide specialized services equivalent to "active treatment" at the time of transfer. (27 violations.)

IV. Failure to complete the Pre-Admission Screening and Resident Review (PASRR) processes. (750 violations.)

The federally prescribed tool to seamlessly transfer clients from one long-term care setting to another is PASRR. While it is reasonable to expect the 27 transferred residents would continue, initially, to receive specialized services in Lakeland Village nursing facility equivalent to the "active treatment" they were receiving in Lakeland IFC/IID just prior to transfer; the amount, duration and scope of specialized services is fluid and subject to reevaluation. It is the PASRR process which triggers the first and ongoing reevaluations of the residents' needs.

A. PASRR level I noncompliance. (27 violations)

Upon admission to Lakeland Village nursing facility, each resident should have received a PASRR level I screening. 42 CFR 483.106(b) ("*An individual is a new admission if he or she is admitted to any NF for the first time.*"); 42 CFR 483.106(a) (the state must require preadmission screening of all individuals with mental illness (MI) or mental retardation (MR) (now referred to as intellectual disability) who apply as new admissions to Medicaid nursing facilities); 42 CFR 483.128 (generally). The screening is a two-part process. The first is called a Level I screening which identifies "*all individuals who are suspected of having MI or MR as defined in §483.102.*" 42 CFR 483.128(a). We find that the nursing facility did not perform the PASRR Level I screenings on any of the 27 transferred residents at the time of admission by failing, in every instance, to complete section III of the PASRR level I form. (27 violations.)

B. PASRR level II noncompliance. (27 violations)

Each of the 27 transferred residents showed indications of MI or developmental disabilities (DD), accordingly each should have received a PASRR level II screening "within an annual average of 7 to 9 working days" after the Level I screening.[3] 42 CFR 483.112(c). We find that none of the transferred residents timely received the required PASRR level II screening. (27 violations.)

[3] Section III of the PASRR level I form, if it had been completed, would have triggered the PASRR Level II screening

C. Repeat PASRR level I and failed completion of PASRR level II. (81 violations)

The state attempted to remedy the incomplete PASRR level I admission screenings by preparing them (again) over a year and a half later during January and February 2013. We do find that the state did complete the PASRR level I screenings at this later time; however, the state failed to complete the PASRR level II evaluations yet again.

Level II PASRR evaluations must identify the name and professional title of the person who performed the evaluation. 42 CFR 483.128(i)(1). It is the practitioner's signature which indicates that a document is complete. The signature is also an attestation by the reviewer as to the authenticity and accuracy of the document's contents. In the case of the 2013 prepared PASRR level II evaluations, none of the forms for the 27 transferred residents were signed. Indeed, half the documents failed even to identify who was completing them.

Only personnel from the state mental health or intellectual disability authority may conduct a PASRR level II evaluation. 42 CFR 483.112(c). Federal law expressly prohibits internal nursing facility staff from performing PASRR level II evaluations. 42 CFR 483.106(e)(iii) (Disqualifying any NF staff or entity "*that has a direct or indirect affiliation or relationship*" to the NF.) Approximately half of the unsigned forms were filled out by Nurse Curry who was employed by Lakeland. Nurse Curry filled out the PASRR level II forms on the residents for whom she completed the PASRR level I forms. The other half of the PASRR level II forms were filled out without any identifying information, but were possibly filled out by Nurse Kalesnick who completed the PASRR level I screenings for those same residents. Nurse Kalesnick was also employed by Lakeland.

Question B.1 of the PASRR level II form asks the reviewer to complete a narrative about "*the person's developmental strengths and developmental needs*" and "*areas of primary concern identified on the DDD Assessment/LTC Assessment, Assessment for Specialized Services, and other assessments.*" Arguably, this is the most important part of the form for the subsequent development of the comprehensive plan of care. Yet, for each of the 27 transferred residents, this important assessment narrative was left blank; there was no identification of primary areas of concern and no evidence that any assessments had been performed.

We conclude that the state's 2013 attempt to comply with PASRR level II evaluation requirements was unsuccessful because the forms were not completed in their entirety and were left unsigned. We also find the attempt to be unsuccessful because the persons who filled out the forms were, or possibly were, unauthorized to complete them and prohibited from doing so. As a consequence, the state violated 42 CFR 483.106(a), 42 CFR 483.112(b) and 42 CFR 483.128. (81 violations.)

D. Failure to create evaluation report. (597 violations)

The State is required to relay the results of the PASRR determination to the clients in writing in an evaluation report. 42 CFR 483.112(c)(2); 42 CFR 483.128(i) ("*For individualized PASARR*

determinations, findings must be issued in the form of a written evaluative report.") There is no evidence that any of the PASRR determinations, not the original incomplete PASRR level I screenings, the repeat 2013 PASRR level I screenings, nor the failed 2013 PASRR level II determinations, resulted in any written evaluation reports. We find that the State failed to complete any of the required PASRR evaluation reports for the 27 transferred residents. (81 violations.) That failure, in turn, caused the state not to:

1. Interpret and explain the reports to the transferred residents, their families or legal representatives. 42 CFR 483.128(k). (81 violations.)
2. Supply copies of the reports to the state, the attending physicians, and to the transferred residents. 42 CFR 483.128(*l*)(1), (2), and (4). (81 violations.)
3. Provide the transferred residents, their families or legal representatives with alternative placement options. 42 CFR 483.130(*l*)(3). (81 violations.)
4. Inform the transferred residents, their families or legal representatives that they had the right to appeal and to contest the transfer to a nursing facility in the first place, or to choose a different nursing facility or a new ICF. 42 CFR 483.130(*l*)(4). (81 violations.)
5. Provide the transferred residents, their families or legal representatives with assurances that needed specialized services could and would be provided or arranged for by the State. 42 CFR 483.130(n). (81 violations.)

E. Failure to repeat the PASRR level II screenings after changes in circumstances. (30 violations)

A significant change a resident's physical or mental condition triggers an obligation on the nursing facility to notify the State authority of the need to conduct a reevaluation of the resident's needs. SSA §1919(e)(7)(B)(iii). At least three residents appeared to have had significant changes in their physical or mental conditions after placement into Lakeland Village facility. Nonetheless, the nursing facility did not ask the state to reevaluate the individuals (3 violations). That failure, in turn, caused the state not to:

1. Perform new level II evaluations. (3 violations.)
2. Create new evaluation reports. (3 violations.)
3. Interpret and explain the reports to the transferred residents, their families or legal representatives. 42 CFR 483.128(k). (3 violations.)
4. Supply copies of the reports to the state, the attending physicians, and to the transferred residents. 42 CFR 483.128(*l*) (1), (2), and (4). (9 violations.)
5. Provide the transferred residents, their families or legal representatives with alternative placement options (if any). 42CFR 483.130(*l*)(3). (3 violations.)
6. Inform the transferred residents, their families or legal representatives that they had the right to appeal and to contest the new determinations and changes in services (if any). 42 CFR 483.130(*l*)(4). (3 violations.)

7. Provide the transferred residents, their families or legal representatives with assurances that needed specialized services could and would be provided or arranged for by the State (if any). 42 CFR 483.130(n). (3 violations.)

We find that the state violated §1919(e)(7)(B)(iii) of the Social Security Act.

V. Failure to deliver specialized services. (19,854 violations)

As previously found, Lakeland Village nursing facility did not perform either level of PASRR screening. The question remains, then, whether the 27 residents nonetheless received the necessary specialized services despite the failure to perform PASRR evaluations. Our review of the medical records indicates the residents did not receive specialized services.

The state is obligated to provide each resident with specialized services. 42 CFR 483.116(b)(2) ("*The State must provide or arrange for the provision of the specialized services needed by the individual while he or she resides in a nursing facility.*"); 42 CFR 483.130(m)(1). These services include, but are not limited to, physical therapy (PT), speech-language pathology (ST), occupational therapy (OT), and mental health rehabilitative services for mental illness and intellectual disability. 42 CFR 483.45(a). The State's PASRR level II form also identifies these additional specialized services: housing, housing with structural modifications, personal care, recreation, direct nursing care, nursing consultation, behavioral intervention, employment program, community access, transportation, adaptive supports, equipment, sensory stimulation, and augmentive communication.

In the medical records provided, there is little evidence that the transferred residents have been receiving any specialized services, let alone all of the services to which they are entitled. There is no evidence that the ICF/IID "active treatment" services were continued after transfer. There is no evidence that any of the specialized services identified in the incomplete PASRR level II screenings were ever considered or implemented.[4] There are no comprehensive plans of care mentioning specialized services. There are no comprehensive care plans or medical records discussing or providing specialized services that are also basic state plan services such as physical therapy, speech-language therapy, and occupational therapy. There is no evidence that outside health care practitioners have been coming on premises to deliver specialized services. There is no evidence that the on-site nursing staff is supplying any service above and beyond nursing facility level of care. In sum, we find that none of the transferred residents have received, or are receiving, the specialized services to which they are entitled.

Since the obligation to provide specialized services is continuous, we find the state in continuous violation of 42 CFR 483.116(b)(2) and 42 CFR 483.130(m)(1); with a new violation occurring each day, for each resident, since their admission to Lakeland Village facility.. (19,854 violations and counting.[5])

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[4] A typical list of specialized services the 27 transferred residents would need included: housing, housing with structural modifications, PT, OT, ST, massage, hydro therapy, personal care, recreation, direct nursing care, nursing consultation, behavioral intervention, transportation, adaptive supports, equipment, and sensory stimulation.

[5] Excluding the 7-9 grace period immediately after admission, and not counting the days of noncompliance for two residents for whom the state failed to provide PASRR documentation entirely, through August 31, 2013.

VI. Failure to prepare timely and comprehensive assessments upon admission. (8 violations)

At the time of admission, Lakeland Village nursing facility is required to perform a comprehensive assessment. 42 CFR 483.20(b)(2)(i)(a facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission.) The state provided no evidence that Lakeland performed the required comprehensive assessment on four of the transferred residents at admission. The provided documentation also showed that four other residents' admission assessments were late. We find that Lakeland Village nursing facility did not perform four assessments, did not perform four others timely and that it violated 42 CFR 483.20(b)(2)(i). (8 violations.)

VII. Failure to prepare complete and comprehensive assessments upon admission. (19 violations)

A comprehensive admission assessment must include the following information about the resident:

(i) Identification and demographic information.
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge potential.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment.
The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. 42 CFR 483.20(b)(1).

Thirteen of the residents received an admission assessment through a report variously entitled "admission review" or "admission summary" or "admission assessment." This report did not have an assessment in five of the required areas: customary routine, activities pursuit, special treatments and procedures, MDS triggered additional assessments, and documentation that the resident participated in the assessment. The report also did not indicate that the reviewer had direct observation and

communication with the resident, nor did it indicate that the reviewer had communication with licensed and non-licensed direct care staff members on all shifts.

Six of the residents received an admission assessment through a report entitled "discharge summary." This report did not have an assessment in seven of the required areas: customary routine, vision, mood and behavior patterns, dental and nutritional status, special treatments and procedures, MDS triggered additional assessments, and documentation that the resident participated in the assessment. The report also did not indicate that the reviewer had direct observation and communication with the resident, nor did it indicate that the reviewer had communication with licensed and non-licensed direct care staff members on all shifts. Frequently, the report was also unsigned.

We find that Lakeland Village nursing facility failed to create a complete admission assessments on 19 of the transferred residents and that the nursing facility violated 42 CFR 483.20(b)(1). (19 violations.)[6]

VIII. Failure to sign and certify assessments. (24 violations)

A registered nurse must sign and certify every comprehensive assessment for completeness. 42 CFR 483.20(i). In all but three of the admissions, the comprehensive assessment report was unsigned and uncertified. (24 violations.)

IX. Failure to prepare timely and comprehensive care plans after comprehensive assessments. (27 violations.)

A comprehensive care plan must be completed within 7 days after completion of the comprehensive admission assessment. 42 CFR 483.20(k)(2)(i). None of the clients had a comprehensive care plan prepared within 7 days after completion of the original admitting comprehensive assessment. (27 violations.)

X. Failure to prepare annual updates to the comprehensive care plans. (74 violations)

Comprehensive assessments are repeated annually. 42 CFR 483.20(b)(2)(iii). The Regional Office did not ask the state to produce copies of the 27 residents' annual assessments, so this aspect of regulatory compliance was not reviewed. However, the annual comprehensive assessment, in turn, triggers the creation or revision of the comprehensive care plan. 42 CFR 483.20(k)(2)(i). Thus, the record should contain comprehensive care plans for 2011, 2012 and 2013 for each resident. It does not. Of the expected 81 such plans, only 10 are present. Similarly, there should be three additional updated comprehensive care plans associated with the three residents who had significant changes in circumstances (which trigger assessments, and their corresponding comprehensive care plans). These,

[6] Lakeland Village facility must use the resident assessment instrument specified by the state when conducting comprehensive assessments. 42 CFR 483.20(b)(1). There is no explanation why the facility is using discharge summaries in the admission process, nor is there evidence that either the admission review or the discharge summaries are state-sanctioned resident assessment instruments.

too, are not present in the record. We conclude that the missing comprehensive care plans were not prepared as required. (74 violations.)

XI. Failure to complete the comprehensive care plans using an interdisciplinary team. (81 violations)

A comprehensive care plan must be prepared by an "an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative." 42 CFR 483.20(k)(2)(ii). No comprehensive care plan anywhere in the record shows that it was created by an interdisciplinary team. (81 violations.)

XII. Failure to include required content in the comprehensive care plans. (243 violations)

A. Objectives and timetables.

The comprehensive care plan must include "*measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.*" 42 CFR 483.20(k)(1). Seventy one of the records were never created. Of the ten records present, none provide any meaningful objectives or timetables. (81 violations.)

B. Identification of services to maximize function.

The comprehensive care plan must describe "*the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.25.*" 42 CFR 483.20(k)(1). Seventy one of the records were never created. Of the ten records present, none identify any services. None identify the client's "highest practical" functioning or wellbeing. (81 violations.)

C. Identification of specialized services.

The comprehensive care plan must identify the specialized services that the resident is to receive. 42 CFR 483.45(a). Seventy one of the records were never created. Of the ten records present, none identify any specialized services. (81 violations.)

XIII. Failure to record resident activities in an objective manner, linked to specific comprehensive plan of care objectives, used to determine the efficacy of the activity or progression toward goals.

Lakeland must maintain records "*on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.*" 42 CFR 483.75(*l*)(1). The clinical records must document the services provided. 42 CFR 483.75(*l*)(5). The Regional Office of CMS did not ask the state to produce all the medical records for the 27 transferred residents. However, Disability Rights Washington (DRW), a private, federally-

funded nonprofit organization which advocates on behalf of people with disabilities, also investigated the Lakeland conversion of the 27 residents from IFC/IID residency to nursing facility residency. DRW presented its findings to the state in a letter dated October 31, 2012. DRW's findings were based on a review of eight of the residents. These records were included in the attachments to the DRW letter provided to the Regional Office.

We find that the DRW review is a valid representative sample of the 27 transferred residents, that their findings of inadequate recordkeeping are supported by substantial evidence and that, more probably than not, those same findings of inadequate record keeping are also applicable to the other 19 transferred residents. Based upon the detailed record review by DRW, we find that the Lakeland Village nursing facility has failed to record resident activities in an objective manner, linked to specific comprehensive plan of care objectives, so that the activities recorded can be used to determine the efficacy of the activity or the resident's progression toward goals.[7]

XIV. Lakeland Village facility is not an appropriate setting. (19,854 violations)

IID residents can only be placed in an appropriate setting:

> *Placement of an individual with MI or MR in a NF may be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted either through NF services alone or, where necessary, through NF services supplemented by specialized services provided by or arranged for by the State. 42 CFR 483.126.*

Beginning with the admission of the 27 transferred residents to Lakeland Village nursing facility, and continuing to date, Lakeland Village nursing facility has failed to prepare timely and comprehensive evaluations upon admission, failed to sign and certify assessments, failed to timely perform PASRR level I screenings, failed (twice) to perform PASRR level II screenings, failed to complete evaluation reports, failed to explain to the residents and their families about the specialized services they would need, failed to provide copies of evaluation reports to all required individuals and entities, failed to provide the transferred residents with alternative placement options, failed to give the transferred residents appeal rights, failed to give assurance that specialized services would be delivered, failed initially to maintain specialized services equivalent to the "active treatment" the residents were receiving in the ICF prior to transfer, failed to prepare timely and comprehensive care plans, failed to update comprehensive care plans annually, failed to use interdisciplinary teams to prepare comprehensive care plans, failed to include all required content in comprehensive care plans, failed to document resident activities in an objective manner, failed to reassess the comprehensive care plan of individuals after they had significant changes in circumstances and, ultimately, failed to provide most if not all of the specialized services to which the residents were entitled. We find that Lakeland Village nursing facility was not and is not an appropriate setting for any of the 27 transferred residents.

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[7] The number of violations are probably in the thousands, but cannot be quantified at this time.

Since the obligation to place IID residents in an appropriate setting is continuous, we find the state in continuous violation of 42 CFR 483.126; with a new violation occurring each day, for each resident, since their admission to Lakeland Village facility. (19,854 violations and counting.[8])

[8] Excluding the 7-9 grace period immediately after admission, and not counting the days of noncompliance for two residents for whom the state failed to provide PASRR documentation entirely, through August 31, 2013.

CONSEQUENT ACTIONS AND RECOMMENDATIONS

I. Disallowance

A disallowance of federal matching funds from the date of transfer from the Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID to the nursing facility through September 30, 2013 for the 27 residents identified in the Disability Rights Washington (DRW) letter to the state dated October 31, 2012.

The state failed to provide CMS with the actual federal financial participation (FFP) claimed as requested. Consequently, the Regional Office (RO), based on the CMS-64 reports, will be estimating the amount based on the percentage of the total beds occupied by these 27 residents multiplied by the number of days from the date each resident was transferred to Lakeland Village nursing facility through September 30, 2013.[1] The disallowance will continue from September 30, 2013 forward for each transferred resident until each is 100% remediated, as described below.

II. Claiming

The state must provide the RO with written assurance that the state will not claim nursing facility FFP on any of the transferred residents for dates-of-service on and after October 1, 2013 until such time as the state has completed, to RO satisfaction and acceptance, all requirements of this letter, full remediation for the transferred residents claimed, and timely delivery and acceptance of the CAP, as determined by the RO.[2]

III. Remediation

Within 30 days of the date of this letter, the state must provide to the CMS RO:

A. Proof that the State has provided DRW with a copy of this letter and attachments.

B. Proof that the State has provided each of the transferred residents, their families and legal representatives with a copy of the WA PASRR #1, 11/2013 letter and all its attachments.

C. Proof that each of the transferred residents has either:

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[1] Our current estimate is $16 million. The actual disallowance amount will be adjusted consistent with any supporting documentation the state chooses to submit within 14 days of the date of this letter, or which CMS determines is required.

[2] Upon acceptance of the CAP and completion of all the other requirements of this letter, the FFP associated the transferred residents may once again be claimed in the calendar quarter in which complete remediation is achieved (as determined by the RO), unless claiming is otherwise deferred or disallowed for other reasons.

1. Voluntarily and with fully informed state-assistance has been transferred from Lakeland Village nursing facility to an appropriate setting,[3] or
2. Voluntarily agreed to stay at Lakeland Village nursing facility despite being fully informed about the deficiencies identified in this letter. For each resident who voluntarily and with full informed consent chooses to stay at Lakeland Village nursing facility, the state must present proof to the RO that:
   a. The resident has received a complete and accurate PASRR level II determination from a reviewer authorized and trained to complete the determination.
   b. The state has created a timely, complete and accurate evaluation report which was delivered to all required parties.
   c. The state has interpreted and explained the evaluation reports to the residents, their families or legal representatives.
   d. The state has provided the transferred residents, their families or legal representatives with alternative placement options (if any).
   e. The state has informed the transferred residents, their families or legal representatives that they have the right to appeal and to contest the new determinations, changes in services or continued placement at Lakeland Village nursing facility.
   f. The state has provided the transferred residents, their families or legal representatives with assurances that needed specialized services can and will be provided or arranged for by the state.
   g. The resident has received a timely, complete and accurate comprehensive assessment following the PASRR level II determination and recommendations.
   h. The state has created a timely, complete and accurate comprehensive plan of care, by an interdisciplinary team with all necessary specialties, training and experience. The comprehensive plan contains objectives and timetables and a complete identification of the services as required by 42 CFR Part 483.
   i. The state creates timely, complete and accurate documentation recording all resident activities in an objective manner, linked to specific comprehensive plan of care objectives, so that it is possible to determine the efficacy of the activity or the resident's progression toward the objective goals.

[3] Remediation is achieved if/when a resident knowingly and voluntarily accepts transfer to a different nursing facility, ICF or other appropriate setting. 42 CFR 483.132(a)(4) (*"If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs in accordance with § 483.126, another setting such as an ICF/IID (including small, community-based facilities), an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs."*)

j. The state is actually providing identified specialized services to the residents, by individuals with the proper training and licensure to deliver the services, and that the services are delivered according to the comprehensive plan of care continuously thereafter.

k. The state reevaluates the resident completely whenever the resident has a significant change to include all required 42 CFR Part 483 activities (e.g. repeat PASRR level II screenings, assessments, notices, updated comprehensive plans of care, etc.)

l. The state is otherwise in compliance with 42 CFR Part 483 for the transferred residents, and stays in compliance thereafter (as determined by the RO).

IV. Corrective Action

Within 120 days of the date of this letter, the state must provide to the CMS RO:

A. Proof that a state-specified resident assessment instrument exists, that it contains all federally required content, and that it is in use throughout the state. See 42 CFR 483.20(b) (*"A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State."*)

B. A complete Corrective Action Plan (CAP), which will be reviewed and must be determined acceptable by CMS, and which implements programmatic and systemic corrective measures at Lakeland Village nursing facility for all transferred residents that contains at least the following milestones and requirements:

1. **Checklist.** Creation of a comprehensive checklist, to be placed into the records of each transferred resident that details all applicable 42 CFR Part 483 requirements as unique individual items starting with admission and for any other significant events or triggers thereafter. The checklist must document when actions are completed, by whom and when; or why they have not been completed. The checklists must support audit and compliance reviews.

   The CAP regarding the development of the checklist should anticipate RO assistance in the content and development, and that the RO has the right to require changes, where necessary, and the right to determine when the checklist is complete. The state must include in the plan that the final CMS accepted checklist will be provided to DRW. The plan must target implementation of the checklist within 90 days of RO acceptance of the CAP, and anticipate RO review of implementation.

2. **Management directive.** Preparation of an internal Lakeland management directive implementing the mandatory use of the checklist for all transferred residents. The directive must include enforcement mechanisms for failure to use the checklists, failure to add the checklists to the client record, or failure to completely and accurately fill-in the checklists. The plan must target the effective date of the

management directive to ensure applicability concurrent with implementation of the checklist.

3. **Compliance reviews.** Scheduling and performance of compliance reviews quarterly, by a third party, to validate that the checklists are being used, are completely and accurately filled-out, and that all 42 CFR Part 483 requirements are met in at least 95% of the time. The plan must identify the criteria for selection of the third party to ensure that there is no potential real or perceived conflict of interest. The results of the compliance review must be given to the Health Care Authority (HCA), the Department of Social and Health Services (DSHS), CMS RO, and DRW within 30 days after the end of each calendar quarter for at least 8 consecutive quarters. If the compliance review shows that Lakeland is not 100% compliant with 42 CFR Part 483, the results of the compliance report must contain the cause of the non-compliance, a report on the corrective measures taken, and a supplemental schedule to retest compliance to assure that the next quarterly review is 100% compliant. The plan must contain practice runs of the compliance reviews. The plan must target the first operational compliance review to occur in time to review all the transferred residents' files in the quarter the checklists are in use during the entire quarter.

4. **Specialized services budgets.** Creating a methodology to convert comprehensive plan of care prescribed specialized services for each of the transferred residents to their expected FFS costs (i.e. if PT is determined to be an appropriate specialized service for a resident, the costs of that service times the planned number of times it is to be provided during the quarter creates an expected FFS cost or budget for that service). The expected cost of all specialized services for each resident is to be itemized and tabulated, and sent to HCA, DSHS, the RO, and DRW for monitoring. The RO has the right to require modification to the report and its format. The plan must target the delivery of the first specialized services budgets to all parties in the second quarter the checklists are in use.

5. **Specialized services costs.** Preparation by HCA of a report that itemizes and shows all FFS costs for Lakeland Village nursing facility residents. The plan must require HCA to routinely monitor the residents' actual costs against the expected costs derived from the comprehensive plan of care. When the actuals begin to deviate from the expected, the HCA must investigate the deviation and assure that the deviation is explained and does not represent a reduction in services. The report must be provided to DSHS, the RO, and DRW within 30 days after the end of each calendar quarter, and must be provided more frequently if requested. It should be accompanied by a narrative explanation of HCA investigative and corrective activities. The RO has the right to require modification to the report and its format. The plan must target the delivery of the first specialized services cost reports to all parties in the second quarter the checklists are in use.

6. **Non-monetized specialized services.** Preparation of a methodology to monitor and assure that specialized services intended to be provided by the NF staff (and thus

these specialized services would not show up on FFS reports) are being provided as prescribed. When the actuals begin to deviate from the expected, the HCA must investigate the deviation and assure that the deviation is explained and does not represent a reduction in services. The methodology must have a concrete deliverable provided to DSHS, the RO, and DRW within 30 days after the end of each calendar quarter, and must be provided more frequently if requested. The deliverable report must explain HCA investigative and corrective activities undertaken in response to the data. The RO has the right to require modification to the report and its format. The plan must target the delivery of the first non-monetized specialized services reports to all parties in the second quarter in which the checklists are in use.

7. **Contact information.** Identification of, and contact information for, HCA staff, DSHS staff, Lakeland staff and all others who are assigned to monitor the creation, implementation and completion of the CAP. The identified contacts must have the authority to direct or effect change.

8. **Single point of contact.** Identification of, and contact information for, a person working at HCA who will be the state's designated single-point-of-contact with whom RO staff will communicate on any matter arising from this letter, required remediation or the CAP.

9. **Assurances.** The state must include in the cover letter to its CAP, the following written assurances:

    a. Compliance with CAP. Agreement that substantial noncompliance with any aspect of the CAP during any part of its implementation, or with the terms of this letter, as determined by the CMS RO, will result in a continuation or additional deferral of FFP for all transferred residents for the quarters where the RO finds substantial noncompliance.

    b. Disallowance. Understanding and acceptance that two or more consecutive quarters of substantial noncompliance with any aspect of the CAP, or with the terms of this letter, as determined by the RO, will result in disallowance of FFP for all transferred residents beginning with the first non-complying quarter and continuing for each subsequent quarter until substantial compliance is achieved, as determined by the RO. The quarter in which substantial compliance is achieved is eligible again for FFP claiming.

    c. Transfers. Written assurance that the state will not transfer any of the 25 surviving residents from Lakeland Village nursing facility to any other setting without :

        - Good cause and only as permitted and authorized by 42 CFR Part 483; and

- First providing complete, accurate and timely notice to the resident, a family member or legal representative, and to the resident's primary care provider.

d. Production of documents. Written assurance that the state will deliver to the RO within 14 calendar days, in the form and format requested by the RO, any documentation requested by the RO related to the transferred residents, the CAP or this letter, subject to RO granted good cause delay for extenuating circumstances.

10. **Deferral.** Deferral of federal matching funds related to costs for all other residents of Lakeland Village nursing facility will be processed beginning with claims reported on the CMS-64 for quarter ending December 31, 2013, and will continue until CMS receipt and acceptance of all of the items/actions specified above. Any subsequent decisions regarding changing the deferral status to a disallowance will be made quarterly.

ARTMENT OF HEALTH & HUMAN SERVICES
enters for Medicare & Medicaid Services
attle Regional Office
1 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104
Centers of Medicaid and CHIP Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

JAN 0 9 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: 10-FA-2014-WA-01-D

Dear Ms. Teeter and Ms. Lindeblad:

The purpose of this letter is to advise you that the Centers for Medicare & Medicaid Services (CMS) has completed Financial Management Review (FMR) of the Long Term Care Facilities Requirements and Preadmission Screening and Resident Review (PASRR) at Lakeland Village Nursing Facility. The objective of the review was to determine if the NF was compliant with Section 1919 of the Act and 42 CFR Part 483 (PASRR) for the 27 residents transferred from the ICF/IID to the nursing facility.

I found that the state did not provide Level II Preadmission screenings of these new admissions for the period June 2011 to March 2014. The state owned and operated nursing facility is substantially non-compliant with Section 1919 of the Act and 42 CFR Part 483 (PASRR). The state failed to complete the PASRR processes as required and consequently the state has improperly received FFP for nursing facility costs claimed.

CMS reviewed the state's accounting records, nursing facility supporting documentation and client files for the period June 2011 to March 2014. CMS determined that the state claimed $5,345,604 FFP for the period June 2011 through September 2013 that is not allowable. These claims that the state agency made for 27 nursing facility residents at Lakeland Village Nursing Facility are unallowable per Section 1919(c)(7)(D)(i) of the Act and federal regulation 42 CFR 483.122(b). The state did not claim any FFP for the 27 nursing facility residents for the period of October 1, 2013 to March 31, 2014.

Please respond to the findings and recommendations contained in the enclosed report within thirty (30) days from the date of this letter. Your response should include:

1. A statement of concurrence or non-concurrence in each finding and recommendation.

2. Where you concur, please describe corrective actions taken or planned and the target dates of completion.

3. Where you do not concur, please give specific reasons for your non-concurrence and any alternative corrective action taken or planned and target for this action.

4. Copies of policies, procedures, and other information which document corrective action.

We would like to thank the State of Washington for their cooperation during this review. If you or your staff have any questions regarding this request please contact Frank A. Schneider of my staff at (206) 615-2335 or via E-mail at fschneider@cms.hhs.gov

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Attachment: 10-FA-2014-WA-01-D Report

Financial Management Review

Long Term Care Facilities Requirements and Preadmission Screening and Resident Review (PASRR) at Lakeland Village Nursing Facility

JUNE 1, 2011, THROUGH MARCH 31, 2014

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

DRAFT REPORT

January 2015

Control Number 10-FA-2014-WA-01-D

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION 10, SEATTLE, WASHINGTON

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EXECUTIVE SUMMARY

The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act (the Act), is a combined federal-state entitlement program that provides medical assistance to certain individuals and families with low incomes and limited resources. Each state Medicaid program is administered by the state in accordance with an approved state plan. While the state has considerable flexibility in designing its state plan, it must comply with federal requirements specified in the Medicaid statute, regulations, and program guidance. The Centers for Medicare & Medicaid Services (CMS) is responsible for federal oversight of the Medicaid program. CMS approves each state plan and all state plan amendments and certifies all claims for federal financial participation (FFP) to ensure funds are spent in accordance with federal requirements.

In 2011, the State of Washington converted part of Lakeland Village, a state-owned property licensed as an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID), into a state-owned Nursing Facility (NF). Twenty seven residents with intellectual disabilities were subsequently discharged from Lakeland Village ICF/IID and admitted into Lakeland Village Nursing Facility. This change did not result in most of the residents actually "moving" into a different facility, but rather a change in the certification for the cottages in which most of the residents were residing from an ICF/IID to a NF.

Section 1919 of the Act and 42 CFR Part 483 (Long Term Care Facilities Requirements and Preadmission Screening and Resident Review (PASRR)) states that new residents of a nursing facility should receive Level II screenings before admission. Per 42 CFR 483.106(b), an individual is a new admission if he or she is admitted to any NF for the first time. Per 42 CFR 483.106(a), the state must require preadmission screening of all individuals with mental illness (MI) or intellectual disabilities (ID) who apply as new admissions to Medicaid nursing facilities. Per 42 CFR 483.128, the screening is a two-part process. The first is called a Level I screening which identifies "all individuals who are suspected of having MI or ID as defined in §483.102." Furthermore, each individual should have received a PASRR Level II screening before admission per 42 CFR 483.112(c).

The objective of the review was to determine if the NF was compliant with Section 1919 of the Act and 42 CFR Part 483 (PASRR) for the 27 residents transferred from the ICF/IID to the nursing facility.

We found that the state did not provide Level II Preadmission screenings of these new admissions for the period June 2011 to March 2014. The state owned and operated nursing facility is substantially non-compliant with Section 1919 of the Act and 42 CFR Part 483 (PASRR). The state failed to complete the PASRR processes as required and consequently the state has improperly received FFP for nursing facility costs claimed.

CMS reviewed the state's accounting records, nursing facility supporting documentation and client files for the period June 2011 to March 2014. CMS determined that the state claimed $5,345,604 FFP for the period June 2011 through September 2013 that is not allowable. These claims that the state agency made for 27 nursing facility residents at Lakeland Village Nursing Facility are unallowable per Section 1919(c)(7)(D)(i) of the Act and federal regulation 42 CFR

483.122(b). The state did not claim any FFP for the 27 nursing facility residents for the period of October 1, 2013 to March 31, 2014.

We request the state refund $5,345,604 FFP on the next CMS-64 for the quarter ending December 31, 2014 and provide CMS assurance that no claims will be reported for the period of October 1, 2013 to March 31, 2014. Failure to refund this amount may result in disallowance action.

I. INTRODUCTION

A. BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is responsible for assuring state compliance with federal statutory and regulatory requirements for states and long term care facilities, as specified in Section 1919 of the Social Security Act (the Act) and 42 CFR Part 483 (Long Term Care Facilities Requirements and Preadmission Screening and Resident Review (PASRR)). This Financial Management Review (FMR) presents the findings, associated federal financial participation (FFP) and required corrective actions based on CMS review of state compliance with those requirements at Lakeland Village Nursing Facility in Medical Lake, Washington, a state-owned and operated long term care facility, specific to 27 residents who were transferred from the Lakeland Village Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID) to Lakeland Village Nursing Facility in 2011.

In 2011, the State of Washington converted part of Lakeland Village, a state-owned property licensed as an ICF/IID, into a state-owned nursing facility (NF). Twenty seven ICF/IID residents, Individuals with Intellectual Disabilities (IID), were subsequently discharged from Lakeland Village ICF/IID and admitted into Lakeland Village Nursing Facility. This change did not result in most of the residents actually "moving" into a different facility, but rather a change in the certification for the cottages in which most of the residents were residing from an ICF/IID to a NF. The discharges from the ICF/IID occurred on June 2 or June 3, 2011 for all 27 residents. Lakeland Village Nursing Facility accepted all 27 residents as new admissions on the same day as the residents were discharged from the ICF/IID.

Disability Rights Washington (DRW), a private, federally-funded nonprofit organization which advocates on behalf of people with disabilities, investigated the conversion and subsequent transfer of the residents. In October, 2012, DRW presented its findings to the State of Washington Department of Social and Health Services (DSHS) alleging that the discharge of the residents from the ICF/IID was without good cause as it was primarily intended to save the state money, that mandatory screenings and evaluation requirements were ignored (Preadmission Screening and Resident Review or PASRR), and that the transferred residents were harmed by losing federally-mandated specialized services after the conversion.

The Seattle Regional Office (RO) obtained a copy of the DRW findings, initiated discussions with the state that resulted in other concerns being identified and requested and received documents. In August 2013, the RO completed its review of more than 5,000 pages of documentation. A preliminary findings letter was issued on November 7, 2013 and the state initiated remedial and corrective actions as articulated in the letter.

B. OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the Financial Management Review was to determine if the state owned and operated NF was compliant with Section 1919 of the Act and 42 CFR Part 483 (PASRR) for the 27 residents transferred from the ICF/IID to the nursing facility.

Scope

CMS reviewed the state's nursing facility supporting documentation, client records and accounting records from June 2011, through March 31, 2014 to determine whether or not federal requirements at Section 1919 of the Act and 42 CFR Part 438 (PASRR) had been met.

Methodology

To accomplish the objective, CMS:

- reviewed state and federal laws, regulations, and polices applicable to Long Term Care Facilities Requirements and PASRR requirements;
- interviewed state officials about the program and reporting requirements; and,
- reviewed the state's accounting records, nursing facility supporting documentation and client files.

II. FINDINGS AND RECOMMENDATIONS

Findings

CMS found the state was out of compliance with Section 1919 of the Act and 42 CFR Part 438 (PASRR). The state failed to complete the PASRR processes as required and consequently the state has improperly received FFP for nursing facility costs claimed for the 27 ICF/IID residents, who were subsequently discharged from Lakeland Village ICF/IID and admitted into Lakeland Village Nursing Facility. Per Section 1919(e)(7)(D)(i) of the Act; and 42 CFR 483.122(b), the failure to perform a required PASRR evaluations results in the complete forfeiture of FFP for all nursing facility services until the PASRR evaluations are subsequently completed.

Based on our review, we determined:

- All 27 residents were new admissions to Lakeland Village Nursing Facility; as such the state was required to perform PASRR evaluations. See Washington state plan section 4.39, page 79a; and 42 CFR 483.106(b) ("An individual is a new admission if he or she is admitted to any NF for the first time."); 42 CFR 483.106(a) (the state must require preadmission screening of all individuals with mental illness (MI) or mental retardation (MR) (now referred to as intellectual disability) who apply as new admissions to Medicaid nursing facilities). The screening is a two-part process. The first is called a Level I PASRR screening which identifies "all individuals who are suspected of having MI or MR as defined in §42 CFR 483.102" and 42 CFR 483.128(a); the second is a Preadmission Level II screening (also called a Level II evaluation and determination) as defined under 42 CFR 483.112). Each of the 27 transferred residents was known to have ID or a related condition, by definition, as ICF/IID residents. Accordingly, each should have received a PASRR Level II screening, whether or not the state used the mechanism of Level I to make the referrals for Level II.

- PASRR Level II Noncompliance. Prior to admission to Lakeland Village Nursing Facility, each of the 27 new admissions should have received a PASRR Level II Preadmission screening. The purpose of the pre-admission screen per 42 CFR 438.112(a) is: "For each NF applicant with MI or MR, the State mental health or mental retardation authority (as appropriate) must determine, in accordance with §483.130, whether, because of the resident's physical and mental condition, the individual requires the Level of services provided by a NF." Admitting an individual with MI or ID may "be considered appropriate only when the individual's needs are such that he or she meets the minimum standards for admission and the individual's needs for treatment do not exceed the level of services which can be delivered in the NF to which the individual is admitted through NF services alone or, where necessary, through NF services supplemented by specialized services provided or arranged for by the state." (42 CFR 438.126). The Level II requirements include a determination of the appropriateness of the placement; a determination of the individual's needs and which specialized services they may require; and a process to ensure the participation of the resident, his or her primary care provider, and (if appropriate) family members in the placement and service decisions. CMS determined that the State of Washington failed to perform the Level II Preadmission Screening on any of the 27 transferred residents and that Lakeland Village Nursing Facility improperly admitted the individuals in the absence of those Level II evaluations and determinations; thereby resulting in the state's subsequent failure to ensure that the NF was an appropriate placement and to assess the need for and subsequently provide needed specialized services. We found that none of the transferred residents timely received the required PASRR Level II screening from the transfer date in June 2011 until March 2014.

- A Level II PASRR evaluation and determination is complex, with specific content and process requirements. A Level II PASRR evaluation is "performed" within the meaning of 42 CFR 483.122(b) when all parts of the Level II PASRR evaluation, determinations, and process requirements have been completed to regulatory requirements and so that the regulatory aims have been achieved. These include but are not limited to 42 CFR 483.112 (second level review for evaluation of specialized services); 42 CFR 483.128(a) (describing Level II); 42 CFR 483.128(i) (Level II contents); 42 CFR 483.136. In this case, we found that the state did not perform a Level II PASRR evaluation on <u>any</u> of the 27 residents before admission to Lakeland Village Nursing Facility.

- Because the state failed to perform the Level II PASRR evaluation process prior to admission to Lakeland Village Nursing Facility, and the facility nonetheless admitted the individuals, no services above and beyond a nursing facility services level of care were provided from admission through (at least) early 2013. This despite the fact that the individuals had previously received such services that were beyond the nursing facility level of care as Active Treatment in the ICF/IID.

- Good cause is required to discharge residents from an ICF/IID. 42 CFR 483.440(b)(4)(i). See also survey guidance for tag W-201: "Transfer or discharge occurs only when the facility cannot meet the individual's needs, the individual no longer requires an active treatment program in an ICF/IID setting, the individual/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living

situation, either internal or external, would be more beneficial, . . . Moving an individual for "good cause" means for any reason that is in the best interest of the individual." The decision to move 27 residents from Lakeland Village ICF to Lakeland Village Nursing Facility was "part of DSHS's efforts to reduce expenditures due to state revenue shortfalls." (Director Cody letter, May 15, 2013, page 2.) The state's effort to reduce expenditures is not a good cause. PASRR would have been the objective means to make "a determination . . . that another level of service or living situation, either internal or external, would be more beneficial," taking into account each individual's unique needs. In addition to being a requirement for admission to a NF, PASRR would have established (or ruled out) good cause for discharge from the ICF/IID. The state did not present or provide any evidence, PASRR or otherwise, of having assessed the individual's unique circumstances. Accordingly, the state discharged the 27 residents from the ICF/IID without good cause.

After receipt of the DRW findings in late 2012, the state made two attempts to perform the Level II PASRR evaluations as Resident Reviews, one during January and February 2013, and again during November and December 2013. However in both attempts, the state's efforts did not comply with Level II PASRR requirements (evaluation, determinations, and process requirements). (*See the Attachment to this report for a full description of the deficiencies identified for both reviews*)

Per Section 1919(e)(7)(D)(i) of the Act; and 42 CFR 483.122(b), the failure to perform required PASRR evaluations results in the complete forfeiture of FFP for all nursing facility services until the PASRR evaluations are subsequently completed.

As such, the state's claims are not supportable due to non-compliance with 42 CFR Part 483 (PASRR) and 42 CFR 483.122 (FFP for NF Services). The state claimed $5,345,604 FFP for 27 nursing facility residents at Lakeland Village Nursing Facility for the period of June 2011 through September 2013. These claims that the state agency made for 27 nursing facility residents at Lakeland Village Nursing Facility are unallowable per Section 1919(c)(7)(D)(i) of the Act and federal regulation 42 CFR 483.122(b).

CMS determined that all PASRRs were fully completed in March 2014. The state did not claim any FFP for these 27 individuals for the period of October 1, 2013 to March 31, 2014.

Recommendations:

CMS request the state to:

1. Ensure no additional FFP is claimed for the 27 individuals transferred to the Lakeland Village Nursing Facility in 2011 for the period October 1, 2013 through March 31, 2014.

2. Return $5,345,604 FFP for the claims that were paid for nursing facility services provided to the 27 residents during the time PASRRs were not completed (June 2011 through September 2013).

Detailed Findings

1. A statewide budget shortfall was the primary motivating cause of the conversion of part of Lakeland Village ICF/IID into a nursing facility.
2. Lakeland Village ICF/IID resident costs are greater than Lakeland Village Nursing Facility resident costs.
3. The January and February 2013 efforts did not substantially comply with Level II PASRR requirements (evaluation, determinations, and process requirements) in that:
    a. Eleven of the (state) Form 14-303 documents failed to identify the name and professional title of the person who completed them. 42 CFR 483.128(i)(1).
    b. None of the (state) Forms 15-168 identified the name and professional title of the person(s) who completed the forms, or when the forms were completed. 42 CFR 483.128(i)(1).
    c. The person or persons who completed the DSHS Forms 14-303 and 15-168 were not state developmental disabilities authority personnel qualified and trained to perform the evaluations. 42 CFR 483.106(e).
    d. The evaluations did not include a summary of the residents' medical and social history. 42 CFR 483.128(i)(2).
    e. The evaluations did not address the positive traits, developmental strengths and weaknesses, and developmental needs of each resident. 42 CFR 483.128(i)(2).
    f. The evaluations did not address each resident's total needs and whether those needs could be met better in a community setting, and what the appropriate community setting would be. 42 CFR 483.132(a)(1).
    g. The evaluations did not address whether each resident's total needs were such that they could only be met on an inpatient basis. 42 CFR 483.132(a)(2).
    h. The evaluations did not address whether the residents' total needs were such that they could be met by placement in a home and community-based services (HCBS) waiver program, 42 CFR 483.132(a)(2).
    i. The evaluations did not address whether Lakeland Village Nursing Facility was an appropriate institutional setting for meeting the residents' total needs. 42 CFR 483.132(a)(3).
    j. The evaluations did not address whether the residents expressed their desires to be in that particular facility. 42 CFR 483.132(a)(3).
    k. The evaluations did not address whether the residents' needs exceeded the level of services which could be delivered in Lakeland Village Nursing Facility either through nursing facility services alone or, where necessary, through services supplemented by specialized services provided by or arranged for by the state. 42 CFR 483.126; 42 CFR 483.132(a)(3).
    l. The evaluations did not address the possibility that, notwithstanding the fact that the residents wanted to stay in the facility, and that nursing facility level of care was appropriate, whether a different facility would nonetheless have been more appropriate (such as an intermediate care facility for individuals with intellectual disabilities (ICF/IID), small, community-based facilities, an institution for mental disease (IMD) providing services to individuals aged 65 or older, or a psychiatric hospital). 42 CFR 483.132(a)(4).

m. The evaluations did not identify whether specialized services were needed. 42 CFR 483.130(l)(1).
n. The evaluations did not show that the evaluator reviewed each resident's comprehensive history and physical examination results, or that the evaluator had other equivalent information to assess each resident's medical problems, the impact those medical problems had upon the resident's independent functioning, and the current medications used by the resident. 42 CFR 483.136(b).
o. The evaluations did not show that the evaluator considered each resident's physical status (for example, diagnoses, date of onset, medical history, and prognosis). 42 CFR 483.132(c)(1).
p. The evaluations did not show that the evaluator considered each resident's mental status (for example, diagnoses, date of onset, medical history, likelihood that the resident may be a danger to himself/herself or others). 42 CFR 483.132(c)(2).
q. The evaluations did not show that the evaluator considered and evaluated each resident's functional assessment (i.e. activities of daily living). 42 CFR 483.132(c)(3).
r. The evaluation did not show that the evaluator reviewed each resident's intellectual functioning and test measurements as performed by a licensed psychologist. 42 CFR 483.136(c).
s. The evaluations did not show that the evaluator determined whether or not each resident needed a "continuous specialized services program," which was analogous to ICF/IID "active treatment." 42 CFR 483.136(a). No document shows that the evaluator was aware of the concept of ICF/IID "active treatment." The documents do not describe the "active treatment" the residents received in the ICF/IID. The documents do not show the evaluator's professional opinion on the resident's highest possible functional status that would grant the resident as much self-determination and independence as possible, if the resident were given an "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services" to help the resident achieve that level of functioning. 42 CFR 483.440(a)(1)(i). The documents do not show the evaluator's professional opinion on how the resident could acquire the behaviors necessary for the resident to achieve this high functional status. Id. The documents do not show the evaluator's professional opinion on what the "program of specialized and generic training, treatment, health services and related services" might look like. Id. The documents do not show the evaluator's professional opinion whether the client was at risk of "regression or loss of current optimal functional status." 42 CFR 483.440(a)(1)(ii). If there was risk of "regression or loss of current optimal functional status" the documents do not show the evaluator's professional opinion on the best way to prevent or slow the decline, through an "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services."
t. The evaluations were not provided to the residents and to the residents' legal representatives. 42 CFR 483.128(l)(1); 42 CFR 483.130(k).
u. The evaluations were not provided to the residents' attending physicians. 42 CFR 483.128(l)(4); 42 CFR 483.130(k).
v. The evaluations were not interpreted and orally explained to the residents, their families or legal representatives. 42 CFR 483.128(k); 42 CFR 483.128(b).

w. The evaluations did not address all the placement options that were available to the resident, given his/her service needs. 42 CFR 483.130(l)(3).
x. The evaluations did not make express assurances to the resident that "the specialized services that are needed can and will be provided or arranged for by the state while the individual resides in the NF." 42 CFR 483.130(n).
y. The evaluations did not inform the resident of the right to appeal the findings and conclusions in the evaluation to a state fair hearing. 42 CFR 483.130(l)(4); 42 CFR 483.204.

4. In November and December 2013, the state made its second attempt to perform the Level II PASRR evaluations. Included in the second attempt, as part of the Level II PASRR evaluation, was a PASRR Level II form, a Specialized Services Assessment, a DDA Assessment, a Planned Action Notice, a Request for Hearing Form and a "Roads to Community Living" brochure. As with the first attempt, the November and December 2013 efforts still did not substantially comply with Level II PASRR requirements (evaluation, determinations, and process requirements) in that:
   a. While the PASRR Level II forms had a signature for the person who completed them, the other component parts of the second-attempt evaluation package did not identify who completed them. 42 CFR 483.128(i)(1).
   b. The evaluations did not include a summary of the residents' medical and social history. 42 CFR 483.128(i)(2).
   c. The evaluations did not address each resident's total needs and whether those needs could be met better in a community setting, and what the appropriate community setting would be. 42 CFR 483.132(a)(1).
   d. The evaluations did not address whether each resident's total needs were such that they could only be met on an inpatient basis. 42 CFR 483.132(a)(2).
   e. The evaluations did not address whether the residents' total needs were such that they could be met by placement in a home and community-based services (HCBS) waiver program, 42 CFR 483.132(a)(2).
   f. The evaluations did not address whether Lakeland Village Nursing Facility was an appropriate institutional setting for meeting the residents' total needs. 42 CFR 483.132(a)(3).
   g. The evaluations did not address whether the residents' needs exceeded the level of services which could be delivered in Lakeland Village Nursing Facility either through nursing facility services alone or, where necessary, through services supplemented by specialized services provided by or arranged for by the state. 42 CFR 483.126; 42 CFR 483.132(a)(3).
   h. The evaluations did not address the possibility that, notwithstanding the fact that the residents wanted to stay in the facility, and that nursing facility level of care was appropriate, whether a different facility would nonetheless have been more appropriate (such as an intermediate care facility for individuals with intellectual disabilities (ICF/IID), small, community-based facilities, an institution for mental disease (IMD) providing services to individuals aged 65 or older, or a psychiatric hospital). 42 CFR 483.132(a)(4).
   i. The evaluations did not adequately identify whether specialized services were needed and what those services would be. 42 CFR 483.130(l)(1). While the Specialized Services Assessment would create an aggregate score indicating whether specialized services would be likely, the assessment tool also identified

16 areas where the resident was less than fully independent. Accordingly, it was incumbent upon the evaluator to consider each assessed characteristic and to make a qualitative judgment about the nature of the resident's deficiency and whether it could be mitigated or improved through the provision of specialized services so that the resident could function with as much self-determination and independence as possible. 42 CFR 483.440(a)(1)(i). Uniformly, the Specialized Services Assessment did not translate the noted deficiencies, or its aggregate score, into actual specialized services recommendations.

j. Similarly, the DDA Assessment identified the resident's lack of full independence and functioning in thirty four areas: Home Living, Community Living, Lifelong Learning Activities, Employment, Health and Safety, Social Activities, Protection/Advocacy, Exceptional Medical Supports, Exceptional Behavioral Supports, Communication, Mental/Physical Health, Medication Management, Self-Direction in Treatments/Programs/Therapies, Sleep, Memory, Decision-Making, Living Environment, Locomotion, Mobility, Transfer, Eating, Toilet Use, Continence, Dressing, Personal Hygiene, Bathing, Foot Care, Skin Care, Meal Preparation, Nutrition, Housework, Shopping, Transportation, and Socialization. None of the thirty four areas were then assessed for "active treatment" and specialized service needs; beginning with whether the resident was at maximum functional capacity in each area (thus, not needing "active treatment" or specialized services at all), but if not, identifying of the full range of nursing facility services, specialized services, and "lesser intensity" intellectual disability or mental health services which the state and facility must provide to bring the resident closer to full independence and self-determination.

k. The evaluations did not address and prioritize the resident's physical and mental needs, taking into account the severity of each condition. 42 CFR 483.132(b).

l. The evaluations did not show that the evaluator reviewed each resident's comprehensive history and physical examination results, or that the evaluator had other equivalent information to assess each resident's medical problems, the impact those medical problems had upon the resident's independent functioning, and the current medications used by the resident. 42 CFR 483.136(b).

m. The evaluation did not show that the evaluator reviewed each resident's intellectual functioning and test measurements as performed by a licensed psychologist. 42 CFR 483.136(c).

n. The evaluations did not show that the evaluator determined whether or not each resident needed a "continuous specialized services program," which was analogous to ICF/IID "active treatment." 42 CFR 483.136(a). No document shows that the evaluator was aware of the concept of ICF/IID "active treatment." The documents do not describe the "active treatment" the resident would receive in the ICF/IID. The documents do not show the evaluator's professional opinion on the resident's highest possible functional status that would grant the resident as much self-determination and independence as possible, if the resident were given an "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services" to help the resident achieve that level of functioning. 42 CFR 483.440(a)(1)(i). The documents do not show the evaluator's professional opinion on how the resident could acquire the behaviors necessary for the resident to achieve this high functional status. Id.

The documents do not show the evaluator's professional opinion on what the "program of specialized and generic training, treatment, health services and related services" might look like. Id. The documents do not show the evaluator's professional opinion whether the client was at risk of "regression or loss of current optimal functional status." 42 CFR 483.440(a)(1)(ii). If there was risk of "regression or loss of current optimal functional status" the documents do not show the evaluator's professional opinion on the best way to prevent or slow the decline, through an "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services."

o. The evaluations were not interpreted and orally explained to the residents, their families or legal representatives. 42 CFR 483.128(k); 42 CFR 483.128(b).

p. The evaluations did not address all the placement options that were available to the resident, given the resident's service needs. 42 CFR 483.130(l)(3).

q. The evaluations did not make express assurances to the resident that "the specialized services that are needed can and will be provided or arranged for by the state while the individual resides in the NF." 42 CFR 483.130(n).

5. In March 2014, the state made its third attempt to perform the Level II PASRR evaluations. We found that these Level II PASRR evaluations were, on whole, substantially compliant with the evaluation, determinations, and process requirements of 42 CFR Part 483.

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

Via Facsimile and Federal Express

NOTICE OF TERMINATION OF MEDICARE PROVIDER AGREEMENT

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 05, 2015

James Ward Tappero, Administrator
Lakeland Village Nursing Facility
State Hwy 902 & Salnave Road
Medical Lake, WA 99022

CMS Certification Number: 50-A263

Dear Mr. Tappero:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Lakeland Village Nursing Facility no longer meets the requirements for participation as a provider of services in the Medicaid program established under Title XVIX of the Social Security Act. This is to notify you that effective **March 19, 2015**, the Secretary of the Department of Health and Human Services will terminate its provider agreement with Lakeland Village Nursing Facility. We will publish a legal notice in the Spokane newspaper (The Spokesman-Review) fifteen days prior to the termination date.

Background

To participate as a provider of services in the Medicare and Medicaid Programs, a long term care facility must meet all of the requirements established by the Secretary of Health and Human Services. When a long term care facility is found to be out of substantial compliance, the facility no longer meets the requirements for participation as a provider of services in the Medicare/Medicaid program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a long term care facility's Medicare/Medicaid provider agreement if the facility no longer meets the federal requirements. Regulations at 42 Code of Federal Regulations (CFR) 489.53 and 42 CFR 488.456 authorize CMS to terminate Medicare/Medicaid provider agreements when a provider, such as Lakeland Village Nursing Facility is not in substantial compliance with the requirements of participation for long term care facilities.

On September 19, 2014, the CMS completed a Federal survey at Lakeland Village Nursing Facility. This survey found that Lakeland Village Nursing Facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare and/or Medicaid programs and that the most serious deficiency constituted actual harm that is not immediate jeopardy to residents (Scope/Severity = G). The results of the survey were sent to you October 15, 2014. The following requirements were not met and that this constitutes substantial compliance:

42 CFR § 483.10	Residents Rights
42 CFR § 483.13	Resident Behavior & Facility Practice
42 CFR § 483.15	Quality of Life
42 CFR 483.25	Quality of Care (Actual Harm)
42 CFR § 483.45	Specialized Rehab Services
42 CFR § 483.75	Administration

Because Lakeland Village Nursing Facility is not in substantial compliance, we are imposing a mandatory denial of payment in accordance with the following:

- **Denial of Payments for New Medicare and Medicaid Admissions, as authorized by the Social Security Act, Section 1819(h)(2)(D) and (E) and Section 1919(h)(2)(C) and (D), and implemented at 42 CFR 488.417(b).**

This action is effective for Medicare and Medicaid admissions made on or after **December 19, 2014.** The denial of payments for new admissions also applies to Medicare and Medicaid patients who are members of managed care plans.

An Informal Dispute Resolution (IDR) was requested by Lakeland Village Nursing Facility and convened on January 06, 2015. The results of the IDR did not affect the scope or severity of the deficiency cited in the September 19, 2014 Federal survey.

On January 16, 2015, a State agency recertification and revisit survey found that Lakeland Village Nursing Facility remained out of compliance with Medicare/Medicaid requirements for nursing homes. The State survey agency sent the facility's Plan of Corrections (PoC) to the CMS Region 10 Office on March 03, 2015. The State survey agency and CMS reviewed and found this PoC to be acceptable with an allegation of compliance date of March 06, 2015. Pending the results of a Federal Revisit survey, the allegation of compliance date will be used to determine if the facility will be back in substantial compliance with Medicare/Medicaid requirements prior to the termination date.

CMS also reviewed Lakeland Village Nursing Facility's survey history over the past several years. There have been nine surveys by the State survey agency dating back to March 14, 2012: actual harm was identified as the most serious deficiency in 6 of the 9 surveys. **Based** on Lakeland Village Nursing Facility's **inability to achieve and sustain substantial compliance, the facility's Medicare and Medicaid agreement will be terminated effective March 19, 2015.** This action is taken pursuant to §§ 1819(h), 1919 (h) and 1866(b) of the Social Security Act, implemented at 42 CFR §§ 488.456 and 489.53.

Public Notice of Termination

In accordance with 42 CFR § 488.456, we are publishing a notice of this termination in the The Spokesman Review .

Medicare and Medicaid Payment for Services Following Termination

Under 42 CFR § 489.55, Medicare payment is available up to 30 days following the termination date for those Medicare beneficiaries who were admitted prior to December 19, 2014. Under 42 CFR § 441.11, Medicaid payments may also continue for services rendered for up to a maximum of 30 days following the termination date. The State survey agency has agreed to make reasonable and timely efforts to transfer Medicare and Medicaid eligible residents to other facilities or to alternate care. It is CMS' and the State survey agency's commitment to take into consideration the actions necessary for a proper and safe transition of the residents.

Appeal Rights

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Chief, Civil Remedies Division
Departmental Appeals Board
Cohen Building, Room G-644
330 Independence Avenue, SW
Washington, D. C. 20201

Also send a copy of your request to:

Chief Counsel
Office of General Counsel, DHHS
701 Fifth Avenue, Suite 1600
Seattle, Washington 98104

A request for a hearing must contain the information specified in 42 CFR § 498.40(b) and must identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

If you have further questions, please contact Patrick Thrift of my staff at (206) 615-3811.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

cc: Washington Department of Social and Health Services (DSHS), Residential Care Services
Washington Medicaid
Washington State Ombudsman
Office of General Counsel, DHHS

Washington State Department of Social and Health Services

News Release

Transforming Lives

March 11, 2015
Release No.. 015-0XX

The Developmental Disabilities Administration provides residential services, day services and support services for clients with developmental and intellectual disabilities. It offers a continuum of care to clients by providing a safe, high-quality array of home, community and facility-based residential and employment services. Its team of 3,200 serves nearly 28,000 individuals each year on a $1.08 billion annual budget.

The Administration operates four Residential Habilitation Centers, serving about 850 people, including about 200 at Lakeland Village.

Contact:
John K. Wiley
Media Relations Manager
(509) 363-4797
wileyjk@dshs.wa.gov

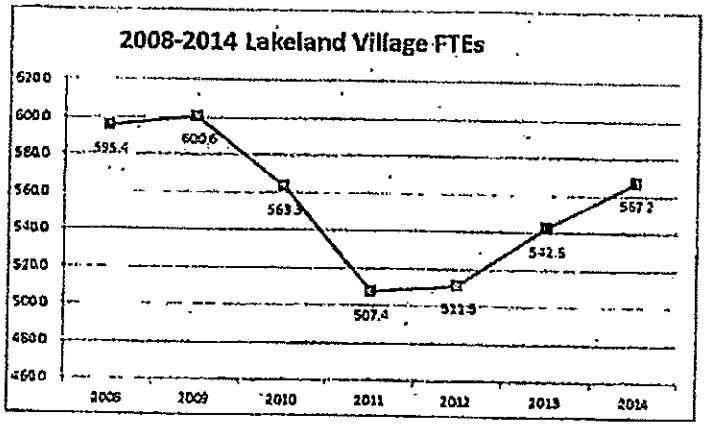
Despite DSHS improvements, federal agency plans decertification of Lakeland Village nursing facility

MEDICAL LAKE -- The federal Centers for Medicare and Medicaid Services (CMS) has notified the Department of Social and Health Services (DSHS) it intends to terminate a provider agreement with Lakeland Village Nursing Facility, effective March 19.

The action, which could result in the loss of federal funding, stems from a series of surveys of the Department's Developmental Disabilities Administration facility at Medical Lake, most recently in January 2015. The continued operation of the facility is not immediately impacted.

The January survey cited 21 violations at the Nursing Facility, none of which alleged actual harm to residents. This represents dramatic improvement from over 40,000 citations in 2013, but it still leaves some items uncorrected.

"We are confident that the facility will soon be returned to full compliance, but there may not be enough time to do so by the CMS deadline," said Evelyn Perez, assistant secretary for DSHS's Developmental Disabilities Administration, which operates the Lakeland Village Residential Habilitation Center (RHC). "The effects of chronic underfunding from previous administrations are still being felt and it will take time to recover."



"Lakeland Village has experienced millions of dollars in reductions, the elimination of programs and the loss of nearly 100 staff positions from 2009-2011," she said. "Recent improvements have been rapid and dramatic but we have simply not yet had enough time to turn things fully around."

Perez said, "We have taken and continue to take major corrective actions at Lakeland including changes in leadership, bringing in senior management teams for weeks at a time, hiring new staff and retraining the entire staff, purchasing new equipment, and asking for independent reviews of our operations by the Health Care Authority and DSHS Residential Care Services.

"We are committed to giving our residents the best possible care and quality of life in a safe, protective environment," Perez said. "We have overspent our budget in order to hire additional staff, because it is the only choice. We have asked the Legislature for additional funding to ensure that we will be able to reach full compliance with our standards and CMS standards"

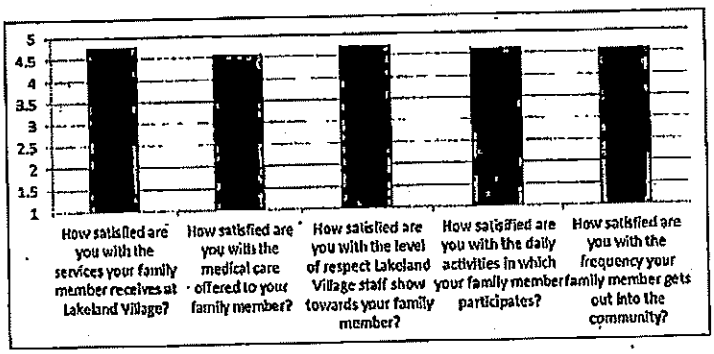
Lakeland Village operates both the nursing facility and an Intermediate Care Facility for Individuals with Intellectual Disabilities. The CMS action only affects residents in the nursing portion.

Perez has been actively keeping parents and guardians informed about progress and development at Lakeland, including a January 2015 meeting with parents and guardians of residents to keep them informed of actions by federal regulators.

Perez emphasized that through all this, Lakeland Village has succeeded in maintaining a strong customer-centered focus. A January survey of parents and guardians of Lakeland residents demonstrated a high degree of satisfaction with the care and attention given to the residents.

The survey, conducted in January by Service Alternatives Training Institute, asked questions about levels of satisfaction with services received, medical care, respect, daily activities and frequency of community outings.

On a 1-5 scale, with 1 being "very unsatisfied," 3 being "satisfied," and 5 being "very satisfied," Lakeland Village scored 4.5 or better on every question



In addition:

- 87 percent of those polled indicated they are routinely contacted about a family member's progress or issues of concern;
- 92 percent said the Lakeland Village staff are knowledgeable in their support of family members, and;
- 88 percent acknowledged they have been informed each year about community placement opportunities for a family member.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Developmental Disabilities Administration
PO Box 45310, Olympia, WA 98504-5310

March 16, 2015

The Honorable Maralyn Chase
218 John A. Cherberg Building
PO Box 40432
Olympia, WA 98504

Dear Senator Chase:

Through our DSHS legislative affairs team you should have received last week a Legislative Alert concerning the likely federal decertification of Lakeland Village, a nursing facility for clients with developmental disabilities, and the likely loss of federal matching funds. This is the latest news in a trail of troubles that dates back to 2013 when authorities found 40,000 violations. The situation today is much improved, however, we are concerned we cannot make all the corrections required to retain federal certification by the March 19, deadline.

I am just back from a week at Lakeland Village along with several members of my staff and want to share with you the many changes we have made and are making. It is important to me that you understand we are working tirelessly to bring the needed changes and that I will not rest until we succeed.

To date the DSHS Developmental Disabilities Administration has:

- Increased active treatment
- Evaluated all nursing facility residents for any needed "specialized services" that would benefit them
- Created new systems for providing important information to parents and guardians of clients
- Replaced the facility's nursing home administrator
- Hired a full time medical director
- Retrained nursing staff, including in pressure ulcer prevention and restorative care
- Implemented multiple new medical protocols
- Solicited more frequent inspections from DSHS Residential Care Services as well as outside inspection from the Health Care Authority
- Initiated monthly pharmaceutical reviews by physician, pharmacist and nursing staff
- Increased staff training in multiple areas of required documentation
- Established a new quality assurance monitoring systems
- Completely eliminated the use of physical restraints like seat belts for 58 of the 85 nursing facility residents, and created restraint reduction plans for many others
- Establish new protocol for toilet use supervision
- Hired two additional specialists to increase recreational activities
- Increased physical therapy treatment options
- Created new kitchen procedures to focus on nutrition quality assurance and consistency of menu, including monthly review by dietician and food service staff

- Modified or ordered new, less restrictive, wheelchairs for multiple clients
- Created weekly peer reviews by nursing staff to ensure all assessments are properly and timely completed
- Expanded training of all staff in safety procedures and cross-contamination prevention
- Developed new infectious control procedures including observation by supervisors to ensure compliance
- Strengthened protocols regarding hazardous chemical storage

Many of these changes are also needed at other of our Residential Habilitation Centers and I am determined to see these changes not just fully implemented at Lakeland Village, but at every one of our RHCs.

I also want to let you know that I have reached out to the parents and guardians of our clients at Lakeland Village to keep them informed. In January I invited them to a town hall style meeting to discuss the details of the corrective work we are doing.

I will keep you informed of our progress, good news or bad. Should you want any additional information, or have any questions, it would be my pleasure to meet with you at your convenience. I am committed to ensuring we meet the requirements for Medicaid certification for the facility and to provide residents the highest quality of care in all areas. Thank you.

Sincerely,

Evelyn Perez, Assistant Secretary
Developmental Disabilities Administration

DSHS: *Transforming Lives*

cc: Andi Smith, Sr. Policy Advisor, Office of Governor Jay Inslee

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Disability Services
Developmental Disabilities Administration
2120 Ryan Road PO Box 600 Buckley WA. 98321

May 7, 2015

Loida Baniqued, Field manager
ICF/IID Survey and Certification Program
Division of Residential Services
PO Box 45600
Olympia WA 98504-5600

Re: Credible allegation of compliance, Annual Recertification Survey 3/2/2015-3/11/2015

Dear Ms. Baniqued,

This letter constitutes the revised credible allegation of compliance for Rainier School PAT A, as required by your letter of April 3, 2015 to Alan McLaughlin. I am also responding to the information you shared on the telephone call on May 4, 2015.

This credible allegation will address all the deficiencies cited under 42 CFR 483.410-W102 Governing Body, 42 CFR 483.420-W122 Client Protections, and 42 CFR 483.440-W195 Active Treatment. By addressing the deficiencies found in each of the specific standards cited under each condition as a response to the Condition level deficiency and responding to the Condition level deficiency itself, Rainier School PAT A believes it has demonstrated that it now meets the Conditions of Participation in Governing Body, Client Protections, and Active Treatment. I have addressed each Condition level deficiency by describing (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur. I will address the Condition of Active Treatment first, followed by the Condition of Client Protections and then the Condition of Governing Body.

42 CFR 483.440-W195 Active Treatment

The Statement of Deficiencies indicates that the facility failed to ensure staff provided a continuous, active treatment program for residents to develop skills for greater independence, failed to encourage residents to make choices and self-manage their daily routines, failed to ensure staff implemented programs which had been developed based on assessed needs, and failed to ensure there were enough staff assigned to meet the needs of all residents.

1) How and when the corrections were made:
   - Staff have been trained in providing a continuous, active treatment program for residents to develop skills for greater independence; encouraging residents to make

choices and self-manage their daily routine and ensuring consistent implementation of programs which have been developed based on client need.

- PAT Director/Assistant Director and professional staff have trained all staff on the concept of "what are you doing and why are you doing it" as well as the 3R's (rotate attention, reinforce appropriate behavior, and redirect inappropriate behavior) as a means of focusing the staff on the connection between their interactions with residents and the resident's IHP.
- Training of all direct care staff on the IHPs for all PAT A residents has been completed.
- Inservice training has occurred for all identified mealtime issues (self-serve, food choices, setting own place setting).
- Nursing staff have been trained on client independence during medication administration.
- In order to ensure that there were enough staff to meet the needs of all residents on the identified living unit one to one staffing was provided to identified resident thereby allowing opportunities throughout his day for self-management and choices.
- PAT A Director and Assistant Director have developed a monitoring tool that demonstrates the level of staff understanding of active treatment requirements and if further training is needed.
- PAT A managers have started and will continue to complete weekly monitoring of active treatment and report monthly to the PAT Director.
- Quality Assurance Advisory Board will also monitor active treatment outcomes.
- All corrections were made by May 1, 2015.

2) The systems that are in place to maintain compliance:

- PAT A managers are working with staff assigned to their house to complete the active treatment checklist and submit the information/data to the PAT Director monthly.
- PAT Director and Assistant Director have developed a monitoring tool to encompass data collected by AC Managers to include any needed training components and ensure that training is occurring.
- ACM's are monitoring weekly and provide a monthly status report to the PAT Director regarding continued opportunities for choice and self-management.
- The PAT Director and/or Assistant Director are monitoring completion of IHP training through a tracking device as IHP/adhocs occur.
- PAT Director and/or Assistant Director are completing random house monitoring on a quarterly basis to determine if clients are being offered the opportunity for choice and self-management.
- Nurse managers are observing and monitoring five random medication passes per quarter related to client independence during medication administration using the Nurse Medication and Treatment Monitor and Medication Cart Inspection.

- If trends or concerns develop from monitoring and spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.
- On a quarterly basis, the Rainier School Quality Assurance Advisory Board will review and discuss the checks and any root cause analyses by the RHC Quality Management Coordinator and report their observations/concerns to the Superintendent.
- New Employee Orientation will occur for all new employees beginning the first Monday of each month and for eight consecutive days.
- AC Managers and/or IDTs are reviewing Incident Reports or other significant events in a resident's life through the morning PAT meeting. Ad hocs will be held as necessary based on the resident's concern.
- Rainier School administration have communicated to PAT A management that whenever an IDT determines that the needs of an individual resident exceed the current staffing capacities of PAT A, PAT A management will request additional staffing. Criteria that would warrant this request are that there is insufficient staffing to implement the resident's active treatment program, to meet the resident's immediate care needs, or to respond to emergencies, injuries or illness. Rainier School administration will review the request, and if administration concurs that additional staff is required, the request will be approved commensurate to the need.

3) How the corrective action will be monitored to ensure the deficient practice does not recur.

- The AC Managers and IDT will review Incident Reports or other significant events in a resident's life through the morning PAT meeting. Ad hocs will be held as necessary based on the resident's concern. The IDT will request additional staffing through a letter (on an as needed basis) to the Superintendent that PAT A management as supported.
- PAT A managers are working with staff assigned to their house completing the active treatment checklist and are submitting the information/data to the PAT Director monthly.
- PAT Director and Assistant Director have developed a monitoring tool to encompass data collected by AC Managers to include any needed training components and ensure that training is occurring.
- The PAT Director or Assistant Director are monitoring completion of IHP training through a tracking device as IHPs/adhocs occur.
- Nurse Managers will provide information to the Director of Nursing as observation occurs related to observing and monitoring 5 random medication passes per quarter.
- AC Managers will provide a monthly status report regarding their observations related to opportunities for choice and self-management. If trends or concerns

develop from monitoring and spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.
- On a quarterly basis, the Rainier School Quality Assurance Advisory Board will review and discuss the checks and any root cause analyses by the RHC Quality Management Coordinator and report their observations/concerns to the Superintendent.
- Staff Development trainers will train all new employees related to active treatment through the New Employee Orientation classes.

42 CFR 483.420 W122 – Client Protections

The Statement of Deficiencies indicates that the facility failed to insure resident rights were protected, residents were free from restraints and were protected from staff neglect. The facility failed to ensure allegations were reported in a timely manner, residents were protected from further abuse, and a significant injury of unknown origin was investigated thoroughly. The facility failed to ensure corrective actions based on investigative results were completed.

1) How and when the corrections were made:
   - All window shades have been removed and window film has been placed on the outside of the affected windows which allow the residents to look out from the inside, but will prevent anyone from looking in.
   - All cards with identifying pictures with dietary information have been removed and placed in the dining book binder of house identified.
   - A thorough assessment of restrictive devices for identified residents was completed by an appropriate professional. The respective client's IDT made consideration as to the relative benefit and harm of the device, and if the device was still needed, completed an abridgement form (adhoc), had the adhoc reviewed by the Human Rights Committee (HRC), had a discussion with the clients' guardians to the risk and benefits of the device, and obtained signatures approving use of device.
   - Rainier School PAT A has completed training on SOP 3.13 regarding monitoring of restraint usage.
   - All staff involved in the incidents cited in the Statement of Deficiencies under tags W125, W128, W149, W153, W155, and W157 are on alternate assignment or have received appropriate disciplinary action or are no longer employed at Rainier School.
   - PAT A has initiated a policy that all incident reports involving injuries of unknown origin will be reviewed by the PAT Director or Assistant Director to ensure there is a clear time frame as to what time the injury was found and going back to when the affected body part was last seen without an injury.
   - All PAT A investigators have been trained to include timeframes in their investigations as they relate to injuries of unknown origin, and to list specific activities the resident was involved in during that time frame to better determine what may have caused the injury. All PAT A staff have been re-trained on DDA Policy

5.13 (the need for immediate reporting of suspected abuse or neglect) and nursing staff have been retrained on the Rainier School medication administration procedure.

- All other citations in the Statement of Deficiencies related to client protections have been corrected.
- All corrections were made by May 1, 2015.

2) The systems that are in place to maintain compliance:

- AC Managers are monitoring their cottages to ensure that protected health information remains private.
- PAT A AC Managers are monitoring all bedroom windows within their assigned home to ensure that no windows have obstructed views to the outside, and all residents have privacy curtains or decorative window film. Rainier School environmental checklist is being used as the verification.
- A comprehensive list was developed by PAT A management (with input by all relevant professionals) of all restrictive devices and supports used on PAT A.
- A thorough assessment of the restrictive device by an appropriate professional was completed. If a restrictive device was assessed as needed it was recommended for implementation and was referred to that client's IDT for consideration as to the relative benefit and harm of the device; completion of an abridgement form (adhoc); and discussion with the clients guardians to the risk and benefits of the device and signatures approving use of device. Once the IDT review had been completed, the information (via ad hoc format) was sent to the Human Rights Committee (HRC) for review.
- All PAT A staff have been re-trained on DDA Policy 5.13 (the need for immediate reporting of suspected abuse or neglect) and nursing staff have been retrained on the Rainier School medication administration procedure.
- All nursing staff have been re-trained on the need to report any incidents involving controlled drugs to CRU at the time of discovery of the incident, per SOP 2.25 Rainier School Incident Management Map.
- AC Managers will report to PAT A Management on a monthly basis regarding direct care staff understanding the requirement of immediate reporting beginning 5/1/15.
- All investigations involving abuse or neglect will be reviewed by PAT A Director or Assistant Director to ensure that any PAT A staff suspected of abuse or neglect is on Alternate Assignment or is otherwise not involved in any direct resident care. Any medication error discovered by nursing administration will trigger a review of the specific nurse's history of medication involved incidents, looking particularly for trends and the outcome for the resident. Nursing administration will review findings with Rainier School administration, and appropriate corrective action will be taken, including removal of staff where indicated.
- All Nurse managers will be make sure plan of corrections are completed prior to allowing nursing staff to return to administering medications.

- All PAT A incident reports involving injuries of unknown origin will be reviewed by the PAT Director and/ or Assistant director to ensure there is a clear time frame as to what time the injury was found and going back to when the affected body part was last seen without an injury.
- All PAT A investigators will include timeframes in their investigations as it relates to injuries of unknown origin. They will also include listing specific activities the resident was involved in during that time frame to better determine what may have caused the injury.

3) How the corrective action will be monitored to ensure the deficient practice does not recur.
   - AC Managers are monitoring on a weekly basis to ensure the identified clients are able to clearly see out of their bedroom windows.
   - AC Managers are monitoring all public areas on the houses on PAT A to ensure no pictures of clients with dietary information or other private information is located in public areas.
   - The PAT Director and/or Assistant Director will complete random house monitoring on a quarterly basis to ensure no client pictures with dietary information or other private information are in public areas.
   - The PAT Director and/or Assistant Director has and will continue to complete random reviews of risk benefits and reduction plans for those clients on PAT A (thru the IHP review process) using devices or supports that are restrictive. If a concern is identified the IHP will be returned for correction. PAT A management will randomly test staff on their knowledge of RS policies, and staff whose knowledge or understanding of the policy is poor will be retrained and/or have remedial corrective action (progressive discipline) taken.
   - All Rainier School nursing staff have been re-trained in the medication administration procedure, and will continue to be retrained twice yearly.
   - Formal re-training on DDA Policy 5.13 will be provided to all staff again in October 2015, and thereafter on an annual basis.
   - Nurse Manager will monitor 2 full medication administration passes for PAT A each quarter.
   - All incidents involving allegations of abuse or neglect will immediately be reported via the Incident Report format. The PAT Director in conjunction with the Incident Management team and Administration will review the allegation and ensure staff suspected of abuse or neglect is placed on Alternate Assignment or is otherwise not involved in any direct resident care.
   - Any medication error discovered by nursing administration will immediately be reported via the Incident Report format. Nursing administration will look for trends and the outcome for the resident. The Director of Nursing in conjunction with the Incident Management team and Administration will review the allegation, determine appropriate corrective action which may include removal of staff when indicated.

- A monitoring tool has been developed and implemented that demonstrates the level of staff understanding of the reporting requirements and the need for further training on this issue.
- The Director of Nursing will complete random reviews of Incident Reports and Plans of Corrections to ensure completion of plans of corrections prior to staff returning to administering medications.
- All incidents involving injuries of unknown origin will be reviewed by the PAT Director or Assistant Director and the Incident Management team to ensure thoroughness of investigation which includes following the Rainier School Incident Management map.
- The Quality Assurance Interdisciplinary Team (QAIDT) will review Risk Benefit Analysis and reduction plans through the IHP review process.
- The Quality Assurance Advisory Board (QAAB) will monitor on a quarterly basis to initiate quality improvement activities if needed.

42 CFR 483.410-W102 Governing Body

The Statement of Deficiencies indicates that the facility did not ensure there were adequate risk benefit analyses for the use of restraints; there were adequate policies addressing the use of chair restraints or there were plans to reduce use of the restraints; did not ensure alarms were used only when there is a need; did not ensure human rights committee and guardians authorizing the use of restraints fully understood all risks and benefits associated with the use of the restraints; did not ensure the residents sitting for long periods of time in restraints were checked and monitored for safety, or that residents were not subjected to alarms going off throughout the day. The statement of deficiencies also states that facility did not meet the Conditions of Participation for active treatment services and client protections, as noted above.

1) How and when the corrections were made:
   - Risk/benefit analysis for the use of restraints:
     The facility has ensured that all residents are free from unnecessary restraints by obtaining a thorough assessment of the restrictive device by an appropriate professional. If a restrictive device was recommended for implementation it was referred to that client's IDT for consideration as to the relative benefit and harm of the device, and if the benefit outweighed the harm, completion of an abridgement form (adhoc); and discussion with the clients' guardians to the risk and benefits of the device. Once the IDT review had been completed, the information (via ad hoc format) was sent to the Human Rights Committee (HRC) for review, and signatures approving use of device were obtained.
   - Policies:
     The facility has ensured that the current SOP addressing the use of chair restraints was updated.
   - Alarms:
     The facility has ensured that alarms used to notify attending staff of residents' movement in their bedroom will only be used during the timeframes designated in

their IHP. The use of an alarm to notify attending staff of the identified residents were reviewed by the resident's IDT to determine if appropriate. If no longer needed the alarm was disconnected. If determined to be appropriate the alarm is only used during the timeframes as designated in their IHP, as reviewed by the HRC and as reviewed and approved by the guardian.

- Further details on how and when corrections were made related to active treatment (W195) and client protections (W122) are described above.
- All corrections were made by May 1, 2015.

2) The systems that are in place to maintain compliance:

- Risk/benefit analysis for the use of restraints:
  Whenever the use of a supportive restraint is suggested for a client by that client's IDT, the facility's OT, PT and nursing staff will assess for appropriateness. If appropriate, the assigned HPA in collaboration with the OT/PT and IDT will determine the specific risk/benefit analysis for the use of the restraint for the specific client. Subsequent to the determination of each specific risk/benefit analysis each plan to use the restraint(s) will be submitted for Human Rights Committee (HRC) and guardian review and approval.
- Policies:
  The current policy addressing the use of chair restraints (Restrictive Device Decisions Guide) has been reviewed by the Standard Operating Procedure (SOP) committee to include direction regarding appropriateness of usage, parameters of usage and monitoring requirements. The policy has been signed by the Superintendent and is in use.
- Alarms:
  Attendant Counselor Managers (ACMs) are performing weekly checks to ensure that the alarms described in a relevant client's IHP are being used as described in that IHP. Monthly reports of these checks are being submitted to the PAT Director for review and action as needed.
- Further details on the systems that are in place to maintain compliance related to active treatment (W195) and client protections (W122) are described above.

3) How the corrective action will be monitored to ensure the deficient practice does not recur:

- Risk/benefit analysis for the use of restraints:
  All restraints used with clients will be reviewed for continued need and/or modification by the client's IDT. If determined to be helpful for the identified client's health and safety the assigned HPA in collaboration with the OT/PT, IDT will determine the specific risk/benefit analysis for the use of restraint for the specific client. Subsequent to the determination of the risk/benefit analysis each plan to use the restraint(s) will be submitted to the HRC for review and guardian review and approval.
- Policies:

The current policy addressing the use of chair restraints has been reviewed and modified by the Standard Operating Procedure (SOP) committee to include direction regarding appropriateness, parameters of usage and monitoring requirements.

- Alarms:

  All alarms used to notify attending staff of a client's movement in and from their own bedroom will only be used during the timeframes designated in their IHP and as reviewed by the HRC and approved by the guardian. Attendant Counselor Managers (ACMs) will perform weekly checks to ensure that the alarms described in a relevant client's IHP are being used as described in that IHP. Monthly reports of these checks will be submitted to the PAT Director for review and action as needed.
- Further details on how the corrective action will be monitored to ensure the deficient practice does not recur related to active treatment (W195) and client protections (W122) are described above.

Respectfully,

Harvey Perez, Superintendent
Rainier School
PO Box 600
Buckley WA 98321

Citation Summary from the Lakeland Village Nursing Facility Survey of 1/22/15

F-167: A resident has the right to examine the results of the most recent survey and any plan of correction in effect.

- Survey results, including citations resulting from complaint investigations, and plans-of-correction were not readily available in 6 of the 7 nursing facility cottages.
- No actual harm.

F-221: Residents have the right to be free from physical restraints that are not required to treat the resident's medical symptoms.

- Three residents with intermittent continued use of restraining devices while in recliner/not following their restraint reduction plan; 2 residents with use of restraining devices while on the toilet (one individual left for 40 minutes and the other person somewhere greater than 10 minutes and without supervision as per the plan-of-care).
- No actual harm.

F226: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

- Failure to implement policy for initiating investigation of a fall for 1 sampled resident.
- No actual harm.

F246: Residents have the right to reside and receive services with reasonable accommodations of individual needs and preferences.

- Failure to accommodate resident need for positioning and comfort while resident in wheelchair and recliner. Lower extremities were left in a dependent position for extended periods of time without support.
- No actual harm.

F278: The assessment must accurately reflect the resident's status.

- Failure to ensure that the Minimum Data Set (MDS), a federal tool used to assess residents, accurately reflected the status of 7 residents. The inaccuracies related to nursing restorative programs and restraint usage (1 resident).
- This placed residents at risk for unidentified declines and unmet needs.
- No actual harm.

F282: The services provided or arranged by the facility must be provided by qualified persons and in accordance with each resident's plan of care.

- Failure to follow the plan-of-care to keep a resident up 30 minutes after meals.
- No actual harm.

F286: All resident assessments completed within the previous 15 months must be maintained in the resident's active record.

- Failure to maintain 15 months of resident MDS assessments OR to be readily available as needed/requested.
- No actual harm.

F287: Within seven days of completing an assessment, the assessment must be encoded and transmitted to CMS.

- Failure to electronically transmit MDS assessments to the CMS system for 2 residents.
- No actual harm.

F309: Each resident must receive necessary care and services to attain the highest possible level of functioning

- Failure to ensure management of dialysis for 1 resident (no contract, failure to coordinate services, failure to assess, document and evaluate)
- Failure to assess a new skin issue when discovered as well as clinically assessing all residents risk for skin breakdown using a risk scale
- Failure to manage pain for a resident who was on palliative care
- Failure to ensure care and services provided to 2 residents who had issues with wheelchair positioning.
- No actual harm

F-323: Resident environment must be as free of accident hazards as is possible.

- Potentially hazardous chemicals not secured in 3 of 7 cottages.
- No actual harm.

F325: Residents maintain acceptable parameters of nutritional status.

- Failure to ensure monitoring and evaluation for interventions put in place for 2 residents at nutritional risk on nutritional supplements.
- Placed at risk for decline.
- No actual harm.

F-327: Residents are given sufficient fluid intake to maintain proper hydration and health.

- Failure to ensure monitoring of MD ordered fluid restriction for 2 residents who were at risk for fluid deficit/fluid overload.
- No actual harm.

F-329: A resident's drug regimen must be free from unnecessary drugs.

- 1 resident was given Versed (for anxiety) which was perceived by the administering nurse to be a seizure
- 2 residents were on psychoactive medication without adequate indication for use, behavioral care plan, monitoring and evaluation to ensure the continued use was appropriate.
- No actual harm.

F-332: The facility must ensure that it is free of medication error rates of five percent or greater.

- Medication error rate from medication pass observations was 14%. This was based on 27 opportunities and 4 errors.
- No actual harm.

F-356: The facility must post nurse staffing data at the beginning of each shift.

- The facility did not post the total number and actual hours worked by licensed nursing staff and certified nurses aides on a daily basis.
- 7 of 7 cottages were without the required nurse staffing posting.
- No actual harm.

F-363: Menus must meet the nutritional needs of residents.

- Recipes were not followed and some menu items did not have recipes.
- Menus were not followed.
- No actual harm.

F-371: The facility must store, prepare, distribute and serve food under sanitary conditions.

- There were sanitation, hand washing, and infection control concerns in the kitchen.
- Staff in cottages were not trained in the safe preparation and serving of food when preparing food for residents in 3 of 7 cottages.
- No actual harm.

F425: The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

- Facility did not ensure the accurate dispensing and administration of drugs.
- Medication administration issues with the crushing of meds that should not be crushed.
- Failure to follow facility policy in the timing of administration of dietary supplements.
- Failure to ensure clear and understandable directives for use of bowel protocol
- No actual harm.

F-428: the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

- Facility failed to ensure the resident's physician responded to the pharmacist's recommendations for 13 of 39 sampled residents.
- No actual harm.

F-441: The facility must maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment.

- Multiple issues with infection control principles to include hand washing, cross-contamination in improper use/removal of gloves, inconsistent donning and doffing of personal protective equipment for residents requiring precautions, inconsistent attentiveness to scheduled cleaning of equipment and devices used by multiple residents and/or same resident (such as the restraining device used by multiple residents on the toilet).
- No actual harm.

F-514: The facility must maintain clinical records on each resident in accordance with accepted professional standards.

- Failure to ensure the timely inclusion of lab reports, hospital admissions, and Dietician evaluations in the clinical record.
- Failure to consistently document the administration of medication and to ensure information was filed in the correct resident record.
- No actual harm.

Citation Summary from the Lakeland Village ICF Survey dated 1/27/15

W-100: This is a federal Condition of Participation for ICF services.

- The facility did not ensure that residents received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports.

W-102: The facility must ensure that specific governing body and management requirements are met.

- The governing body failed to exercise general operating direction over the facility. This resulted in two federal Conditions of Participation not being met. The unmet Conditions included Active Treatment and Client Protections.

W-104: The facility must exercise general policy, budget, and operating direction over the facility.

- Facility maintenance was not completed as needed
- No system was developed to determine when repairs were completed
- Restraints were not used without an assessment and monitoring protocols
- Equipment used by residents was not clean
- "This failure placed residents in the situation of living in homes in need of repair, having to use unsanitary equipment, and to be restrained without proper assessment and safeguard."

W122: The facility must ensure that specific client protection requirements are met.

- Facility failed to develop and implement systems that identified, immediately reported, thoroughly investigated, and documented protections in all allegations of abuse/neglect/mistreatment.
- Facility implemented restrictions without assessments and proper abridgements.

W125: The facility must ensure the rights of all clients.

The facility failed to ensure the rights of 17 residents
Examples include:

- Obstructing views from bedroom windows
- Using mattresses with lips on the edges
- Locking doors in a cottage that prevented moving about the cottage
- Locked up resident's money
- Locked up faucet handles to showers
- Denied free access to resident's personal belongings without due process

W127: The facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

- The facility failed to ensure that residents were not subjected to abuse. The citation described one well-known staff-to-resident incident that resulted in a bruise on the chest for the resident.
- One staff member also stated that he had not read the DDA policy on Abuse (5.13), but had signed the training sheet on file indicating that he had read it.
- There was no follow-up by a cottage manager to ensure that staff reviewed the required written training information.

W130: The facility must ensure privacy during treatment and care of personal needs.

- The facility failed to ensure resident's privacy was protected when using the bathroom, because bathroom windows in one cottage did not have curtains.

W148: The facility must promptly notify parents or guardians about significant incidents or changes in condition.

- The facility failed to inform guardians of allegations of serious incidents involving 8 residents.

W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse.

This failure placed all residents at risk of abuse. The facility failed to:

- Develop and implement policy which resulted in the immediate reporting of allegations of abuse
- Thoroughly investigate all incidents
- Take protection measures when ensured that residents would not be subjected to further abuse/neglect/mistreatment

Specific areas of concern included no documentation of delays in reporting incidents of abuse & neglect to the Administrator resulted in the alleged perpetrator remaining on duty with residents during that time.

W153: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source are reported immediately to the administrator and other officials as required by state law.

- In 6 of 26 incidents that were reviewed, the facility failed to immediately report to the Administrator. This prevented the facility administrator from being able to take immediate protective action.

W154: The facility must have evidence that all alleged violations are thoroughly investigated.

- In 5 of 26 allegations of abuse/neglect/mistreatment, the facility failed to conduct a thorough investigation. This prevented the facility from fully understanding what had happened to residents so that appropriate corrective action could be taken.

W155: The facility must prevent further potential abuse while the investigation is in progress.

- During the investigation of incidents of staff-to-resident abuse, the facility failed to document the implementation of protective actions for 4 residents.
- The examples that were given primarily related to the inability to determine if the delays in notifying the administrator of the alleged incident had resulted in the alleged perpetrator remaining on unsupervised duty with residents.
- The examples of reporting delays were one to three hours.
- Modified staff reassignments allowed continued access to residents and did not provide specific parameters of the reassignment.

W186: The facility must provide sufficient direct care staff to manage and supervise clients.

- The facility failed to ensure that sufficient staff were available to meet the needs of 4 residents.
- Cited examples included observations of residents that were not consistently involved in an active treatment program intended to teach skills or increase independence.
- Documented observation periods were from 1-3 hours on multiple days.
- Direct care staff reported that they had numerous responsibilities which prevented them from consistently implementing individual programming. These responsibilities included taking residents to appointments in the community and on campus, maintaining one-on-one coverage, responding to a resident with convalescent health issues, assuring that meals and snacks were served, meeting health and hygiene needs of residents etc.
- One staff member indicated that a toileting positioning device (restraint) was used when she was unable to remain with the resident during toileting activities.

W192: For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.

- The facility failed to develop and implement a system to assure that staff received training and demonstrated competency for 1 resident who was recovering from a fractured hip.

- No system was developed to assure all staff were trained on the specifics of the resident's walking plan and no oversight to assure the walking plan was properly implemented.

W195: This is a federal Condition of Participation related to Active Treatment.

- The facility failed to develop and implement systems that resulted in residents receiving consistently implemented plans based on functionally assessed needs which promoted self-management and independence.

W196: Each client must receive a continuous active treatment program which includes aggressive, consistent implementation of specialized and generic training, treatment, health and related services directed toward self-determination and independence, and prevention of decline in skills.

- Active treatment program issues were identified for 3 of 12 residents that were reviewed. These issues prevented residents from acquiring skills to increase their independence.

W214: The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.

- The facility failed to assess current daily living skills and identify prioritized needs to be addressed for 2 of 12 residents that were reviewed.

W227: The individual program plan states specific objectives necessary to meet the client's needs.

- The facility failed to develop objectives to address behaviors for 2 of 12 residents reviewed. This impacted resident's ability to function in daily life by not having appropriate interventions developed.

W240: The individual program must describe relevant interventions to support the individual toward independence.

- The facility failed to develop written instructions to staff about the use of a gait belt, a wheelchair, and the implementation of a walking program for 1 resident who was recovering from a fracture. This prevented the resident from functioning at a more independent level.

W242: The individual program must include, for those clients who lack them, training in personal skills essential for privacy and independence.

- The facility failed to include training programs in basic skills areas for 1 of 12 residents reviewed.

W247: The individual program plan must include opportunities for client choice and self-management.

- For 7 residents, the facility failed to create situations which promoted their ability to manage daily routines. The facility adhered to a strict meal time which frequently resulted in residents sitting at the table for extended periods of time waiting for the meal, and not encouraging residents to help prepare their food.

W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program.

- The facility failed to assure individual program plans were consistently implemented for 3 of 12 residents reviewed.

W250: The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

- The facility failed to develop a schedule designed to direct the daily activities of staff and residents in the implementation of active treatment programs for 3 residents. "This failure prevented staff from knowing what to do with the residents."

W255: The individual program must be reviewed by the qualified mental retardation professional and revised as necessary.

- The facility failed to assure revisions were made to the individual habilitation program for 1 of 12 residents reviewed.

W290: "As needed" programs to control inappropriate behavior are not permitted.

- The facility failed to justify the inclusion of a highly restrictive procedure to manage behavior for 1 resident.
- The resident wore an electronic bracelet to assist staff in locating the resident, in the event that he/she could not be found. The device had not been used in more than two years, according to staff.

W301: A client placed in a restraint must be checked at least every 30 minutes by staff trained in the use of restraints.

- No system was developed for staff to monitor residents who were placed in a toilet positioning device that was restrictive. One resident was described in the citation.

W460: Each client must receive a nourishing, well-balanced diet.

- A specially prescribed diet was not followed for 1 resident.

**W 154 Staff Treatment of Clients

- The electronic incident report database will be modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian contact. This will allow for enhanced identification of trends. Modification is expected to be completed by 02/12/15.
- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.
- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.
- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland Village.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency. Superintendent and ICF PAT Director

36 30

**W 155 Staff Treatment of Clients

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- For Residents #13,#14,#15 The Abatement Plan identifies that the Superintendent/Designee will ensure no further potential abuse will occur while the investigation is in progress.

For Resident # 16- The Facility has implemented protective measures for the identified individual by the following:

- The alleged perpetrator was fully reassigned to the [redacted] on January 16, 2015.
- After consultation with the Survey Team the alleged perpetrator was fully reassigned to the [redacted] on January 21, 2015 a position in which she has staff available to ensure supervision at all times.
- A referral related to the incident of alleged abuse was made to [redacted] by the Superintendent on 1/29/15.
- The alleged perpetrator will remain on reassignment with no unsupervised contact with vulnerable adults at Lakeland Village at least until the current investigation by [redacted] is completed.
- The alleged perpetrator was informed of the supervision guidelines contained in the reassignment letter on 01/16/15 and again on 01/21/15.

- The Appointing Authority (Superintendent) has reviewed the Compliance Investigation Manager (CIM) 5-day investigation reports (8/14/14 and 1/23/15) and determined that no other action is needed at this time to protect the identified individual from the alleged perpetrator based on that report. The Appointing Authority notified the guardian on 01/16/15 about the alleged abuse and the actions taken in response.
- The Appointing Authority will take further corrective action related to abuse/neglect if indicated following receipt of the APS investigation.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

All staff at the Facility are mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff have been retrained to mandatory reporting requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

37 39

**W 154 Staff Treatment of Clients

- The electronic incident report database will be modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian contact. This will allow for enhanced identification of trends. Modification is expected to be completed by 02/12/15.
- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.
- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.
- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland Village.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency. Superintendent and ICF PAT Director

36 30

**W 155 Staff Treatment of Clients

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- For Residents #13,#14,#15 The Abatement Plan identifies that the Superintendent/Designee will ensure no further potential abuse will occur while the investigation is in progress.

For Resident # 16- The Facility has implemented protective measures for the identified individual by the following:

- The alleged perpetrator was fully reassigned to the [redacted] on January 16, 2015.
- After consultation with the Survey Team the alleged perpetrator was fully reassigned to the [redacted] on January 21, 2015 a position in which she has staff available to ensure supervision at all times.
- A referral related to the incident of alleged abuse was made to [redacted] by the Superintendent on 1/29/15.
- The alleged perpetrator will remain on reassignment with no unsupervised contact with vulnerable adults at Lakeland Village at least until the current investigation by [redacted] is completed.
- The alleged perpetrator was informed of the supervision guidelines contained in the reassignment letter on 01/16/15 and again on 01/21/15.
- The Appointing Authority (Superintendent) has reviewed the Compliance Investigation Manager (CIM) 5-day investigation reports (8/14/14 and 1/23/15) and determined that no other action is needed at this time to protect the identified individual from the alleged perpetrator based on that report. The Appointing Authority notified the guardian on 01/16/15 about the alleged abuse and the actions taken in response.
- The Appointing Authority will take further corrective action related to abuse/neglect if indicated following receipt of the APS investigation.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

All staff at the Facility are mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff have been retrained to mandatory reporting requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

**W 155 Staff Treatment of Clients

- Notify the on-duty authority to ensure continued client(s) protection.
- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU)..
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting the time when this occurs.
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.
- Ensure facility procedural incident reporting is followed.

The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults at least until all relevant investigations (CIM, APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult.
- The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults at least until all relevant investigations (CIM, APS, and/or law enforcement) are complete.
- In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation

**W 155 Staff Treatment of Clients

- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.

When corrective action will be accomplished? 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?
Superintendent and ICF PAT Director

**W Tag 186 Direct Care Residential Living Unit Staff

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice? #4, #11, #17, #47

- The facility will adjust staffing ratios by reassignments or new hires to meet the individualized needs of residents #4, #11. Resident # 4, #11 were assessed in the past to no longer benefit from Adult Training Programs (ATP), the IDT will reevaluate the needs of residents #4, #11 and reintroduce them to the Adult Training Program area. If residents #4 and #11 are evaluated and Adult Training Programs are without benefit, staff will be assigned to the cottage to assist with (IPP) active treatment training. Staff working at the ATP will be deployed to the cottage to assist with individual program plans (IPP) training needs during breakfast and lunch meals.
- For residents #4 and #11 the facility will explore the potential transfer to another cottage that is not at full capacity of residents (15). The IDT will convene to discuss potential movement within the ICF facility to better match the intensity of needs to cottages that are not at capacity.
- The facility will adjust staffing ratios by reassignments or new hires during shift 2 for residents #4, #11 so adequate staffing are available to provide for individualized Program Plans including the acquisition of skills and opportunities for preferred activities both on and off cottage. Resident #4, #11 will continue to self-manage to the extent possible taking into account their developmental needs. Self-management may include prompting and direct physical assistance with activities of daily living (ADL) to achieve success.
- If additional staffing are required to meet the needs of resident #4 and #11 requests will be made to increase the staffing levels of the specific cottages.
- For Resident # 17 An Evaluation Request has been sent to Occupational Therapy for review of Toilet Positioning Device.
- Based on documentation contained in W-186.It appears that resident #47 did attend the Wrangle Inn for her lunchtime meal. Staff from Adult Training program will provided assistance to meet her choice of eating off cottage.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The facility will adjust staffing ratios by reassignments or new hires in order to have sufficient staff available to address the unique needs of each resident. Active treatment will address individualized client needs and strengths. The goal for each individual will encompass personal skills, home living skills, community living skills, employment skills, in order to increase self-determination and independence.
- The facility will involve each resident in the development of active treatment objects to extent possible based on choice and preference. Cottage staffing ratios will be adjusted beyond minimum staffing ratios in order to meet the continuous active treatment needs of each participant.

**W Tag 186 Direct Care Residential Living Unit Staff

- Staffing ratios for each cottage will be evaluated by the ICF PAT Director/Residential Services Coordinators to include a review of the level of supervision/support needed for each resident to maintain safety and provide aggressive active treatment.
- If staffing needs are found to be inadequate, a request for additional Full Time Employees (FTEs) will be submitted to DDA Central Office.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur?

- Staff expectation will include the need for continuous reinforcement of appropriate behavior, rotation of attention to actively engage individuals in preferred activities designed to promote independence and self-determination.
- Formal programming will be prioritized based on individual needs and choice.
- Active treatment training opportunities will focus on skills necessary to live as independently as possible. Active treatment opportunities will be encouraged during formal training and throughout the day consistent with naturally occurring opportunities.
- Staff will demonstrate formal and informal training during the natural rhythm of each day. Individual formal objects will be measured and advanced based on acquisition of skills.
- The IDT will determine which skills are moved to informal training opportunities and which skills formal collection of data is required.
- Staffing ratios for each cottage will be evaluated by the ICF PAT Director/Residential Services Coordinators based on the level of supervision/support needed for the resident to maintain safety and aggressive active treatment. If staffing needs are found to be inadequate a request for additional FTEs will be submitted to DDA Central Office.
- Circumstances that may require an adjustment in staffing ratios may include but are not limited to: significant change in resident functioning related to medical issues related to resident injury, illness; acuity of behavioral management needs within the cottage or environmental issues needing resolution

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent?

- Each Comprehensive Assessment (Individual Habilitation Plan) and related assessments, combined with individual choice and preferences will formulate the Individualized Program Plan. The QIDP will monitor through data collection and advance objectives as appropriate. The IDT through case conference will meet to suggest changes or eliminate any barriers for continued success. Individuals, Families, Guardians are encouraged to provide input and participation in the Individualized Comprehensive Plan.

**W Tag 186 Direct Care Residential Living Unit Staff

- ACMs/AP Supervisors will begin monthly spot checks to ensure the Individualized Active Treatment Schedules are consistent with resident objectives and occurring at naturally occurring times and submit findings to the QA Team Committee
- ICF PAT Director/Residential Services Coordinators will review staffing ratios as needed and maintain daily communication related to resident needs for support and supervision.

When corrective action will be accomplished? Direct Care Staffing Ratios will be adjusted by 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?

Superintendent, ICF PAT Director, Developmental Disabilities Administrator, Habilitation Program Administrator (HPA)

**W 192 Staff Training Program

Plan of Correction

- How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice
  - Resident # 4 was recovering from a fractured hip sustained on 8/31/2014
    - Upon investigating this deficiency, the Facility found the following information:
    - Training from Physical Therapy (PT) occurred on 9/5/2014 to include, 2 Person stand-Pivot Transfer with gait belt, use of mechanical lift to regain mobility and rely less on the use of a wheelchair. In total, 19 Direct Care Staff signed to report they had been trained by PT, who in-serviced staff on the cottage in in-vivo fashion.
    - For resident #4, PT began on 9/8/2014
    - PT was discontinued on 12/22/2014
    - PT wrote progress 12/22/2014 note that he recommended that Resident #4 should be walked with gait belt by 1-2 staff with 1 staff following with wheelchair.
    - PT last progress note on 12/29/2014 stated that #4 may walk on cottage with gait belt and assistance of 1-2 staff
  - HPA updated Resident #4's IHP to include the current PT recommendations on 1/22/2015 upon receipt of the Therapy Orders from PT.
  - An e-mail was sent to the ACM regarding the need to revisit the expectations of direct care staff related to receiving and the signing for training.
  - A discussion with the PT will emphasize the importance of immediately presenting the Therapy Orders to the QIDP/HPA for inclusion into the IHP/Direct Care Flow Sheets.
- How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?During a resident's hospital stay - Daily communication (day shift) will occur between Team Leader RN or designee and nurse for admitted client in hospital. Contact will be documented on daily contact form and will be entered into progress note section of CUR.
  - On weekend/afterhours- Daily communication between Resource RN (day shift) and nurse at hospital will occur during hospital stay.
  - When date of discharge is determined, the day shift Resource or Team Leader will make contact with nurse at hospital for Nurse to Nurse Verbal Report (on form).
  - If the cottage nurse, staff or RSC is contacted by the hospital staff for a report or discharge information, refer them to the Resource RN or Team Leader RN for report of information.
  - MD/ARNP and HPA will be notified by Team Leader RN/ Resource nurse of discharge Nurse to Nurse report and will receive a copy of the report with any med changes/special therapies/equipment needed.
- For ER visits not resulting in admission to hospital- If client has not returned in 3 hours, the Resource nurse or Team Leader will be contacting the ER nurse for a report on client status. If

afterhours or weekend, the MD/ARNP on-call will be contacted with information and possible orders.

- After discharge packet is received from hospital, the written instructions regarding special care/ health needs related to a client's recent hospital stay or post-op care is in-serviced with appropriate DC staff as required by resident's condition.
- All staff who work with residents who are returning from hospital treatment for any reason or who have identified and assessed needs related to hip fractures/mobility issues will be trained by PT staff for on/off cottage mobility needs and use of adaptive equipment such as gait belts, wheelchairs, necessary mechanical lifts and resident transfers
- The ICF Administrator will meet with the PT to emphasize the importance of immediately presenting the Therapy Orders to the QIDP/HPA for inclusion into the IHP/Direct Care Flow Sheets.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- PT will re-train on the use of gait belts and resident transfers for the Direct Care staff who have responsibility for residents who have suffered a fracture or who have returned from hospital treatment, and will require those staff to demonstrate proper knowledge and competence with those skills.
- PT will ensure that Therapy Orders are presented to the QIDP/HPA immediately for incorporation to the IHP/Direct Care Flow Sheets
- At the time of an incident in which a resident has potentially suffered a fracture, the immediate investigator will ensure, at the time of the incident report, that the PT is notified of a possible fracture
- Whenever a resident returns to the NF following hospital treatment (for any reason), the ICF Administrator will ensure that PT is notified for possible re-assessment of the residents needs.
- Upon receipt of the Medical Provider's consultation with diagnosis the Medical Staff will notify PT to order PT services and begin direct care staff training
- After receiving discharge date and/or information for specialized rehabilitation services required, the Resource RN, Team Leader RN, HPA or RN4 will ensure communication with the appropriate specialty area for needed assessments. An Acute Care Plan will be written within 2 hours with initial treatment orders as directed by MD/ARNP until assessed (e.g. Mobility- The client will remain in wheelchair until assessed by PT and training is provided).

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

**W 192 Staff Training Program

- Direct care staff in-service records will be maintained to indicate all staff have been trained in mobility specialized rehabilitation services.
- The Facility DDA 1/Designee will provide a final review of all incident reports to ensure that timely requests for PT services were made when appropriate and that training of Direct Care Staff has been accomplished as part of the follow up documentation on the incident report.
- A copy of all training records will be submitted to the QA Team Committee for a follow up sampling to ensures the trained staff can demonstrate competencies specifically related to the training they received as evidenced by their signature on the Staff Development Attendance Record.
- QA Team Committee will report trends to the RHC Quality Management Coordinator
- All clients returning from hospital stay with special needs/training required will receive an initial acute care plan describing MD/ARNP orders for care until appropriate specialty area has assessed client and written orders. All DC staff will be trained regarding care via the ACP In-service as well as the specialized training as produced and trained by the specialty area.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?

Superintendent, ICF PAT Director, DDA 1/Designee, QIPD/HPA

**W Tags 195 and 196 Active Treatment

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- For sampled residents #4, #9 and #11, the IDT will carefully review each of their IHPs to ensure that the IHP accurately reflects the resident's specific developmental and behavioral management needs and if so, whether the IHP describes an active treatment program that can reasonably be expected to enable the resident to function with as much self-determination and independence as possible, and/or to prevent or slow the loss of the resident's current functional status.
- Where the IHP is found not to correlate with the resident's strengths and needs as identified in the resident's comprehensive functional assessment, particularly in major life areas (such as personal care, home living skills, community living skills, employment skills, etc.) essential to increasing independence, the IHP will be revised to better reflect the resident's current status and appropriate active treatment objectives. The identified objectives will be prioritized based on the resident current abilities and needs.
- The skills necessary to reaching the prioritized objectives will be identified, and the activities relevant to acquiring those skills will be clearly described. The activities will be based on the resident's abilities, needs, interests, and choices.
- A QIDP will monitor the records of residents #4, #9, and #11 to ensure that the recommendations in their IHPs related to active treatment are being appropriately implemented. Review of the records will focus on whether the resident's active treatment program is being implemented both through formal staff interventions and through informal naturally occurring teachable moments.
- Where review of the records of residents #4, #9, and #11 does not document that the recommendations in their IHPs regarding active treatment are being properly implemented, the QIDP will work with the interdisciplinary team to determine what may be inhibiting full implementation of the active treatment program, and what can be done to ensure that the program is successful going forward. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.
- Where review of the records of residents #4, #9, and #11 indicates that an objective has been achieved or that no progress is being made toward an objective, the QIDP will work with the interdisciplinary team to initiate different interventions to try to achieve the current objective or to move on to the next prioritized objective. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.

**W Tags 195 and 196 Active Treatment

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The IHP for all ICF residents will be reviewed by a QIDP by 4/15/15, regardless of when the resident's next comprehensive annual assessment is due. The QIDP will review each IHP to determine whether it correlates with the resident's comprehensive assessment in regards to the resident's strengths and needs, and if so, whether the IHP describes an active treatment program that can reasonably be expected to enable the resident to function with as much self-determination and independence as possible, and/or to prevent or slow the loss of the resident's current functional status.
- If a resident's IHP indicates that it does not correlate with the resident's strengths and needs as documented in the resident's comprehensive functional assessment, or is otherwise insufficient to enable the ICF to implement an appropriate active treatment program, the reviewing QIDP will arrange for a new IHP to be developed by the IDT as soon as possible.
- If a resident's IHP reasonably correlates with the resident's strengths and needs as documented in the resident's comprehensive assessment, and is either sufficient on its face to enable the ICF to implement an appropriate active treatment program or can be made sufficient with minor modifications, the QIDP will make any necessary modifications and will note in the resident's record that the IHP has been reviewed and approved.
- By 4/15/15, the daily records of a representative sample of all residents whose IHPs have been approved by a QIDP will be reviewed by that staff member to determine whether the active treatment program for each of those residents has been properly implemented. Review of the records will focus on whether the resident's active treatment program is being implemented both through formal staff interventions and through informal naturally occurring teachable moments.
- If the QIDP finds that the resident's records do not document that the recommendations in the resident's IHP regarding active treatment are being properly implemented, the QIDP will work with interdisciplinary team to determine what may be inhibiting full implementation of the active treatment program, and what can be done to ensure that the program is properly implemented going forward. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.
- If the QIDP finds that the resident's records indicate that an objective has been achieved or that no progress is being made toward an objective, the QIDP will work with the interdisciplinary team to initiate different interventions to try to achieve the current objective or to move on to the next prioritized objective. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.

**W Tags 195 and 196 Active Treatment

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- Staff will be trained on the requirements of active treatment. Training will include receipt of specific W Tags and interpretive guidelines.
- The IHP format will be revised and modified to reflect and identify the resident's specific developmental and behavioral management needs.
- The facility will adjust staffing levels and types, including through new hires, wherever a pattern of failure to implement residents' active treatment programs is found to be due to inadequate staffing.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur.

- Through the QIDP Quarterly Reviews, the QIDP/HPA will provide evidence that the IHP format has been revised to reflect developmental and behavioral management needs. The evidence will be the revision dates of the objectives within the Monthly Progress Report and the summary in the Quarterly Review.
- ACMs/AP Supervisors will begin monthly spot checks to ensure the Individualized Active Treatment Schedules are consistent with resident objectives and occurring at naturally occurring times. The results of the spot checks will be documented on a facility monitoring tool, and overall findings will be submitted to the QA Committee and the resident's IDT.
- ICF QA Team Committee will discuss findings of spot checks on a quarterly basis.
- If trends or concerns develop from spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.
- The ICF Administrator will monitor for any patterns of failure to meet active treatment programs and will initiate staff moves or new hires as necessary.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.

ICF PAT Director, DDA 1/QA Team Committee Lead

**W 214 Individual Program Plan (CFA)

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- For Residents # 4 and # 11 the IDT will provide a comprehensive functional assessment that will 1) identify the resident's specific developmental and behavioral management needs and 2) provide an individualized program that describes the supports necessary to assist the resident to learn, play, complete tasks, get around, communicate, hear or see better, control his/her own environment and take care of personal needs in a way suited to the resident's age, gender, and culture.
- Residents # 4 and # 11 assessed needs will be prioritized by the IDT at a special IHP by 4/15/2015
- Individualized programs will be developed to ensure the teaching of skills to increase independence, which includes preferred activities, social needs and developmental capabilities.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The IDT will provide a comprehensive functional assessment that will identify the resident's specific developmental and behavioral management needs and provide an individualized program that describes the supports necessary that assist the resident to learn, play, complete tasks, get around, communicate, hear or see better, control his/her own environment and take care of personal needs in a way suited to the resident's age, gender, and culture.
- The resident's current needs identified in the IHP will be prioritized by 4/15/2015 through special case conferences.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- At the IHP meeting, the family/guardian along with the IDT; QIDP, Psychologist, Nurse, Direct Care Staff and ancillary professionals will be required to discuss assessment results and determine the development of the prioritized needs, programs and services to be included in the annual IHP.
- IDT will ensure that all residents who lack personal skills essential for independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of basic needs) will have

HPSC

**W 214 Individual Program Plan (CFA)

aggressive training programs until it has been demonstrated and clearly documented that the resident is developmentally incapable of acquiring them.

- The resident's current needs identified in the IHP will be prioritized by 4/15/2015 through special case conferences.
- Qualified Intellectual Disability Professional Reviews will be completed quarterly to include all summaries of needs, programs (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of basic needs) and services which summarize and analyze the formal and informal training within the individual habilitation plan.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- HPA group will monitor and review 2 QIDP reviews per quarter and HPA representative will bring monitoring tool results to the ICF/QA meeting for discussion concerning whether or not there is evidence to support that active treatment programs both formal and informal are aggressively occurring.

- If trends are identified that indicate a failure to meet the resident's needs, the QA Team will refer sample results of QIDP Reviews to RHC QMC for root cause analysis and subsequent solutions

When corrective action will be accomplished?
4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.
ICF PAT Director, DDA 1/ICF QA Team Committee Chair

6052

*W 227 Individual Program Plan

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- A formal comprehensive assessment for residents #11 and #.9 will be completed by the IDT for the needs identified in each domain included in the functional assessment.
- The IDT will formally include the assessed outcomes within the IHP and/or BSP as specific objectives necessary to meet the residents needs per the identified comprehensive assessment

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- If behaviors are observed that have not been previously identified through comprehensive assessment process, the IDT will hold a special case conference to address the domains of concern and if needed send a Requested Evaluation to the necessary discipline or call for all new assessments for a comprehensive review.
- The IDT will formally include the assessed outcomes within the IHP and/or BSP as specific objectives necessary to meet the residents needs per the identified comprehensive assessment

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- Qualified Intellectual Disability Professional Reviews will be conducted quarterly. These reviews will cover summaries of case conferences. Requested Evaluations related to domains of concern that are most likely impact on the individual's ability to function in daily life will be analyzed to determine whether the facility is meeting the objectives developed.

- If trends are identified by the DDA 1 that indicate a failure to meet the needs identified in residents' comprehensive assessments, the QA Team will refer a sample of CFAs that fail to meet the residents' needs to the RHC QMC for root cause analysis and subsequent solutions

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

GTD

*W 227 Individual Program Plan

- QA Team Committee members will perform internal audits of QIDP reviews to ensure appropriate interventions and objectives were developed to meet residents' needs and address behavior that may interfere with their ability to function in daily life
- If trends are identified by the DDA 1 that indicate a failure to meet the needs identified in residents' comprehensive assessments, the QA Team will refer a sample of CFAs that fail to meet the residents' needs to the RHC QMC for root cause analysis and subsequent solutions

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.

ICF PAT Director and DDA 1

52 84

**W 240 Individual Program Plan

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- Resident # 4 was recovering from a fractured hip sustained on 8/31/2014
- PT Services will re-train Staff B, C, E, F, G, H, J, and K to include the AC Manager related to the placement, appropriate use of and removal of the gait belt, wheelchair and recommended distances Resident #4 should be walking in order to support individual training programs.
- HPA updated Resident #4's IHP to include the current PT recommendations on 1/22/2015 to include how Resident #4 should be supported in individual training program for walking.
- An e-mail was sent to the ACM regarding the need to revisit the expectations of direct care staff related to receiving and the signing for training.
- A discussion with the PT will emphasize the importance of immediately presenting the Therapy Orders to the QIDP/HPA for inclusion into the IHP/Direct Care Flow Sheets.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- All residents will be assessed by PT annually or by Evaluation Request to identify any resident that may require Specialized Rehab Services such as, transfer, mobility equipment or adaptations and modifications to equipment and/or the environment.
- Individual training programs will be developed based on assessed needs/recommendations
- A discussion with the PT will emphasize the importance of immediately presenting the Therapy Orders to the QIDP/HPA for inclusion into the IHP/Direct Care Flow Sheets.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- All residents will be assessed by PT annually or by Evaluation Request to identify any resident that may require Specialized Rehab Services such as, transfer, mobility equipment or adaptations and modifications to equipment and/or the environment.

- Specialized Rehab Services will recommend the appropriate materials, adaptations and necessary modifications (such as but not limited to; gait belts, wheelchairs, built up

5558

**W 240 Individual Program Plan

toilet seats, adaptive eating utensils, extended reach devices, etc.) needed to promote and support individual training programs.

- Specialized Rehab Services will provide training in the use of appropriate materials, adaptations and necessary modifications (Such as but not limited to; gait belts, wheelchairs, built up toilet seats, adaptive eating utensils, extended reach devices, etc) needed for the delivery of those individualized training programs
- HPA will ensure that individual training programs are written in the IHP, to include the use of appropriate materials, adaptations and necessary modifications, (Such as but not limited to; gait belts, wheelchairs, built up toilet seats, adaptive eating utensils, extended reach devices, etc.) and is accessible by all direct care staff for the delivery of individual training program.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The DDA 1 will complete quarterly spot checks to ensure the individual training programs are written in the IHP, to include the use of appropriate materials, adaptations and necessary modifications, (Such as but not limited to; gait belts, wheelchairs, built up toilet seats, adaptive eating utensils, extended reach devices, etc.) And is accessible by all direct care staff for the delivery of individual training program.

- ICF QA Committee will discuss findings of spot checks on a quarterly basis.

- If trends or concerns develop from spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.

When corrective action will be accomplished? 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency. ICF PAT Director and DDA 1/ICF QA Committee Team Lead

**W 242 Individual Program Plan (Toileting Program)

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- The IDT will meet to assess and determine if Resident #9 is developmentally capable or developmentally incapable of executing a toilet training program.
- The IDT will determine if there is any documentation that an aggressive, well organized and well executed toilet training program has been tried in the past, and if it has, will use the results of that effort to inform current planning.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The IDT will ensure that all residents who lack personal skills essential for privacy and independence will be provided appropriate skills acquisition experiences (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of basic needs) unless it is clearly determined that the resident is developmentally incapable of acquiring such skills.
- The resident needs will be prioritized by the IDT and ensure the skill training is implemented in both formal and informal settings

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- The IDT will ensure that all residents who lack personal skills essential for privacy and independence will be provided appropriate skills acquisition experiences (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of basic needs) unless it is clearly determined that the resident is developmentally incapable of acquiring such skills.
- The resident needs will be prioritized by the IDT and ensure the skill training is implemented in both formal programming and informal teachable moments
- Qualified Intellectual Disability Professional Reviews will be completed quarterly to include all summaries of active treatment programs (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming and communication of basic needs) which analyze the progress of skill acquisition

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

**W 242 Individual Program Plan (Tolleting Program)

- HPA group will review 2 QIDP reviews per quarter and HPA representative will bring monitoring tool results to the ICF/QA meeting for analysis of the progress of skill acquisition, formal programming and informal teachable moments
- If trends are identified that indicate a failure to meet the residents needs per monitoring tool the QA Team will refer sample results of QIDP Reviews to RHC QMC for root cause analysis and subsequent solutions

When corrective action will be accomplished?
4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.

DDA 1, QIDP/HPA

5959

*W 247 Individual Program Plan (Choice Self-Management/Meal Times)

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice? #1, #3, #5, #6, #27, #37, #38

- At naturally occurring teachable moments related to meals, the sample residents will receive daily active treatment that increases independent living skills and promotes choice.
- As part of the IHP review, consideration will be given to the level of involvement with meal preparation each sample resident is capable of (or would be capable of if given guidance and support), and the IHP will specifically describe the level of involvement with meal preparation the resident should have.
- Healthy snacks will always be available for the sample residents unless their individual IHP indicates that eating between meals is contra-indicated. Residents who are capable of picking up the snacks and feeding themselves will be allowed to do so, and residents who need assistance will be regularly offered and provided the snacks.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how it will act to protect individuals in similar situations.

- At naturally occurring teachable moments related to meals, all residents will receive daily active treatment that increases independent living skills and promotes choice.
- As part of the IHP review, consideration will be given to the level of involvement with meal preparation each resident is capable of (or would be capable of if given guidance and support), and the IHP will specifically describe the level of involvement with meal preparation the resident should have.
- Healthy snacks will always be available for all residents unless their individual IHP indicates that eating between meals is contra-indicated. Residents who are capable of picking up the snacks and feeding themselves will be allowed to do so, and residents who need assistance will be regularly offered and provided the snacks.

What Measures will be put into place or systematic changes that will be made to ensure that the deficient practice will not recur?

See above.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur.

- A member of the cottage IDT will be responsible for doing monthly meal-time spot checks to determine if residents are actively engaged in naturally occurring meal-time teachable moments.

- Spot checks will be documented on a QA monitoring tool. The tool will be revised to incorporate this monitoring

- Results from completed monitoring tools will be reviewed at QA committee meetings.

When Corrective action will be accomplished?

4/15/15

The title of the person or persons responsible to ensure correction for each deficiency.

Superintendent, ICF PAT Director, Dietician

**W Tag 249 Program Implementation

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- Related to Resident #3 support socks/knee brace and Resident #7 oral care/groin care/antiperspirant: All Non-Program Services (informal programming) related to support socks, knee brace use, oral care, groin care etc. will be summarized monthly or quarterly (as deemed appropriate) by the responsible discipline within the monthly progress report of the IHP
- Related to Resident #4-community inclusion activities: All community inclusion activities have resumed for Resident # 4.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- All Non-Program Services will have a monthly or quarterly report entered into the database by the responsible discipline and the QIDP will further summarize that information in the Quarterly QIDP review. (The responsible discipline specifies the frequency of reporting-monthly or quarterly).
- If any resident has a medical issue that precludes them from being involved in active treatment activities identified in the IPP, the IPP will be revised to reflect their current medical status and suspend or modify current formal and informal programs until the resident is medical cleared to actively participate

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- HPA will ensure that Non Program Services identified in the IHP will have monthly or quarterly documentation available to include but not limited to the use of adaptive equipment, off campus activities and personal hygiene services identified for residents. (The responsible discipline specifies the frequency of reporting-monthly or quarterly).
- The HPA will ensure the monthly or quarterly NPS documentation is summarized and analyzed in the Quarterly QIDP review.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The HPA group will complete quarterly spot checks to ensure monthly or quarterly documentation is available to include but not limited to the use of adaptive equipment, off campus activities and personal hygiene services identified for residents.
- HPA group will review 2 QIDP reviews per quarter and HPA representative will bring monitoring tool results to the ICF/QA meeting for discussion concerning whether or not there is adequate documentation being completed for each NPS

When corrective action will be accomplished 4/15/2015

5961

**W Tag 249 Program Implementation

The title of the person or persons responsible to ensure correction for each deficiency. DDA/QA Team Committee/Habilitation Plan Administrators

**W Tag 250 Program Implementation (Active Treatment Schedule)

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- Residents #4, #10 and #11 will have an individualized Active Treatment Schedule developed which will guide staff to the proper location and focus of the resident's normal daily routine.
- The Active Treatment Schedule will include formal and informal skill acquisition opportunities as identified in the Comprehensive Functional Assessment (CFA)/Individual Habilitation Plan (IHP)

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The individualized Active Treatment Schedule will be developed for all ICF residents which will guide staff to the proper location and focus of the resident's normal daily routine.
- The Active Treatment Schedule will include formal and informal skill acquisition opportunities as identified in the Comprehensive Functional Assessment (CFA)/Individual Habilitation Plan (IHP)

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- The QIDP/ACM (IDT) will develop an Active Treatment Schedule for each resident based on the identified training needs in the CFA/IHP

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The ACM will provide the ICF PAT Director with copies of all completed individualized Active Treatment Schedules by 4/15/2015
- The ICF PAT Director will inform DDA 1/QA Team Committee when all individualized Active Treatment Schedules are completed.
- ACMs/AP Supervisors will begin monthly spot checks to ensure the individualized Active Treatment Schedules are consistent with resident objectives and occurring at naturally occurring times and submit findings to the QA Team Committee
- ICF QA Committee will discuss findings of spot checks on a quarterly basis.
- If trends or concerns develop from spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.

When corrective action will be accomplished
4/15/2015

**W Tag 250 Program Implementation (Active Treatment Schedule)

- The title of the person or persons responsible to ensure correction for each deficiency.
- Superintendent, ICF PAT Director, DDA 1/QA Team Committee, AP Supervisors

**W Tag 255 Program Monitoring and Change

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- For Resident #9 the IDT has met and determined that the Psychology Associate will revise the objective to reflect a percentage of the baseline of Self Injurious Behavior (SIB)
- If Resident # 9 achieves the objective related to SIB and a medication adjustment is warranted, the provider will complete a Risk/Benefit Analysis to provide a justification for the medication adjustment and submit to the Human Rights Advisory Committee for Review

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- All Behavior Support Plans will be revised to reflect objectives as a percentage of the baseline of the maladaptive behavior.
- When a resident achieves a behavioral objective and a change is required, (such as a medication adjustment, restraint reduction, supervision requirement or specific abridgement of rights, etc.,) the provider or appropriate discipline/IDT will complete a Risk/Benefit Analysis to provide a justification and submit to the Human Rights Advisory Committee for Review

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- All Behavior Support Plans will be revised to reflect objectives as a percentage of the baseline of the maladaptive behavior.
- When a resident achieves a behavioral objective and a change is required, (such as a medication adjustment, restraint reduction, supervision requirement or specific abridgement of rights, etc.,) the provider or appropriate discipline/IDT will complete a Risk/Benefit Analysis to provide a justification and submit to the Human Rights Advisory Committee for Review

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent:

- As behavioral objectives are achieved the justifications will be presented at the monthly Human Rights Advisory Committee meeting for review and approval.

When corrective action will be accomplished 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.

**W Tag 255 Program Monitoring and Change

Superintendent/Human Rights Advisory Chair, DDA 1/ICF PAT Director

**W Tag 290 Management of Inappropriate Client Behavior

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- The statement of deficiencies notes that resident #11 was wearing a code alert bracelet (known as a "Care Tracker"). The bracelet was intended to be used to find resident # 11 in the event he left the cottage unbeknownst to staff. The device was GPS activated allowing for ease is searching. The device has not been used for at least two years, and it has therefore been eliminated (taken off the resident #11 arm).

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The Facility will eliminate the use of a Care Tracker for the one other (non-sampled) individual at the ICF/IID who was wearing one by 02/19/15

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- All interventions addressing the control of inappropriate behavior must be justified by the comprehensive functional assessment and the current level of behavior. Ongoing data must support the continued use. Care Tracker was eliminated for the two individuals. No other individuals are utilizing Care Tracker.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- Any interventions addressing the control of inappropriate behaviors that would be considered restrictive will be reviewed by the IDT and the Human Rights Committee. Any exception to policy must be approved by the Regional Administrator in Region 1.

When corrective action will be accomplished?

Correction will be completed by 02/19/15

65 67

**W Tag 290 Management of Inappropriate Client Behavior

The title of the person or persons responsible to ensure correction for each deficiency.

HPA/Psychologists

**W Tag 301 Physical Restraints

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- Resident # 17 utilizes a toilet positioning device. An Evaluation Request has been sent to Occupational Therapy to assess the need for the device and provide recommendations.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- For all residents who currently utilize physical restraints, an Evaluation Request has been sent to Occupational Therapy to assess the need for the device and provide recommendations.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- When an occupation therapist determines that a physical restraint is necessary, he/she will inform the QIDP/HPA and the QIDP/HPA will complete a Physical Restraint Abridgement of Rights form and submit it to the Human Rights Advisory Committee for review and approval.
- If the Human Rights Advisory Committee approves the request for restraint the Abridgement of Rights form will be sent to the family/guardian for consent.
- The recommended restraint will only be used if the Human Rights Advisory Committee approves and the family/guardian consents to its use.
- The Physical Restraint Abridgement of Rights will include monitoring criteria

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- Human Rights Advisory Committee will monitor through maintaining a database which includes all abridgements of rights for physical restraints
- Specialized Rehabilitation Services will continue to assess resident need annually or by Evaluation Request
- The QIDP/HPA reviews the IHP quarterly, to include the use of restraints.

When corrective action will be accomplished 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency. Superintendent, ICF PAT Director, DDA 1/HRAC Committee Chair

**W Tag 460 Receipt of Nourishing Well-balanced Diet

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice? Resident #5

- 8 ounce cups are now available on cottages to account for any 8 ounce fluid restriction. In the event 8 ounce glasses are unavailable staff will measure fluid and demarcate on the 12 ounce cups in order to provide the required intake of fluids specific to the diet order. All diet orders will be followed as prescribed.
- Each individual diet orders will be will reflect any specific fluid restriction.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- Cottage staff will identify individual diet orders with prescribed fluid intake. 8 ounce cups are now available on cottages.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur?

- 8-ounce cups will be standard on cottages to ensure that residents affected by fluid restrictions are receiving the prescribed diet. Anyone without fluid restriction will be offered additional fluid as appropriate.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur? (i.e, what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent?

- Attendant Counselor Managers will spot check mealtime activities. Attendant Counselor Managers will compare the diet order with the servings offered to residents. Corrective action will be implemented as appropriate.
- The Facility Dietician will observe cottage meals at the identified cottage (Hillside) to ensure compliance with diet orders.

160 20

**W Tag 460 Receipt of Nourishing Well-balanced Diet

When corrective action will be accomplished?

- 4/15/15

The title of the person or persons responsible to ensure correction for each deficiency:

ICF/PAT Director, Attendant Counselor Managers, Dietician

Lakeland Village

**W.100 Intermediate Care Facility Services

Plan of Correction for

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- The facility will complete an individualized comprehensive functional assessment, (CFA)that includes individual strengths and needs. To the extent possible the individual shall participate in the development of the CFA. The CFA will encompass major life areas such as personal skills, home living skills, community living skills and vocational desires.
- Needs are then prioritized and implemented formally. Formal and informal skills acquisition experiences shall be encouraged and reinforced throughout environments and during naturally occurring teaching moments. Active treatment shall mirror naturally occurring living experiences.
- The facility will engage all individuals formally and informally at naturally occurring opportunities to self-manage with or without assistance. Activities of Daily Living (ADLs) will focus on building skills to live at Lakeland Village or available community options.
- Individual choices will be respected and encouraged and will align with "resident rights".
- Individual Habilitation Plan meetings (IHP) will include discussion and information sharing of available resources and connection with the Region 1 Field Service office.
- The facility will continue to support programs such as Roads to Community Living, and Money Follows the Person and encourage participation from individuals, families and guardians.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The facility will complete an individualized CFA, including individual strengths and needs. To the extent possible the individual shall participate in the development of the CFA. The CFA will encompass major life areas such as personal skills, home living skills, community living skills and vocational desires.
- Needs are then prioritized and implemented formally, the prioritized formal skills acquisition experiences shall be encouraged and reinforced throughout environments and during naturally occurring teaching moments. Active treatment shall mirror naturally occurring living experiences.

**W 100 Intermediate Care Facility Services

- The facility will engage all individuals formally and informally at naturally occurring opportunities to self-manage with or without assistance. Activities of Daily Living (ADLS) will focus on building skills to live at Lakeland Village or available community options.
- Individual choices will be respected and encouraged and will align with "resident rights".
- Individual Habilitation Plan meeting (IHP) will include discussion and information sharing of available resources and connection with the Region 1 Field Service office.
- The facility will continue to support programs such as Roads to Community Living, and Money Follows the Person and encourage participation from individuals, families and guardians.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur?

- The facility will adjust staffing needs to accomplish active treatment requirements based on specific developmental disability and challenging behavior.
- Staff will be trained on the requirements of active treatment. Training will include. receipt of the specific W-Tags and interpret guidelines. Staff will focus on identifying specific skills required to be successful at Lakeland Village or transition to the community.
- The facility professional staff/members of the IDT will be required to spend portions of the day seeking input from direct care workers. The professional disciplines will be deployed to cottages to assist in the development of individualized CFA.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur? (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent?

- The facility Developmental Disabilities Administrator will monitor professional staff involvement.
- The ICF/PAT Director will monitor Attendant Counselor Managers and ensure they understand Active Treatment requirements as stated in regulations.
- ACMs will train staff who directly report to them.
- Nurse Managers will train staff who directly report to them.

**W 100 Intermediate Care Facility Services

- Adult Programs Supervisors will train staff who directly report to them.

When corrective action will be accomplished?

- 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?

- Superintendent, ICF PAT Director, DDA 1

**W 102 Governing Body and Management

How will the corrective action be accomplished for the sample individuals found to have been affected by the deficient practice? See W-104, W-195, W-122, W-127

1 Maintenance:

- The facility identifies work orders for facility repairs, replacement and maintenance. Work orders are submitted by facility staff, reviewed by their supervisor to ensure the description of work to be performed is accurate and all required fields are entered. After review by the supervisor the work order form is submitted to the Facility Services Administrator (FSA). Request for work that is considered urgent may be phoned in to the FSA. The FSA then enters the work orders into the Advanced Maintenance Management System (AMMS). Work orders are assigned by number by Central Management Office (CMO) and submitted to Consolidated Support Services (CSS) for assignment to the appropriate personnel to complete the required work. If the FSA determines that the work is urgent, he will directly contact CSS for immediate repair.

- Consolidated Support Services (CSS) was identified as not closing out work orders in AMMS giving the appearance that work is still outstanding. The Lakeland Facility Service Administrator identified as WW is working with the CSS to ensure the CSS team is closing out completed work orders timely. The CSS Facility Manager and CSS Maintenance Manager are required to review and reconcile all uncompleted work orders providing the FSA a time frame as to when the work orders will be completed Reconciliation of work orders between CSS and Lakeland Village is ongoing

#2 Active Treatment:

- For sampled residents #4, #9 and #11, the IDT will carefully review each of their IHPs to ensure that the IHP accurately reflects the resident's specific developmental and behavioral management needs and if so, whether the IHP describes an active treatment program that can reasonably be expected to enable the resident to function with as much self-determination and independence as possible, and/or to prevent or slow the loss of the resident's current functional status.
- Where the IHP is found not to correlate with the resident's strengths and needs as identified in the resident's comprehensive functional assessment, particularly in major life areas (such as personal care, home living skills, community living skills, employment skills, etc.) essential to increasing independence, the IHP will be revised to better reflect the resident's current status and appropriate active treatment objectives. The identified objectives will be prioritized based on the resident current abilities and needs.
- The skills necessary to reaching the prioritized objectives will be identified, and the activities relevant to acquiring those skills will be clearly described. The activities will be based on the resident's abilities, needs, interests, and choices.
- A QIDP will monitor the records of residents #4, #9, and #11 to ensure that the recommendations in their IHPs related to active treatment are being appropriately implemented. Review of the records will focus on whether the resident's active treatment

program is being implemented both through formal staff interventions and through informal naturally occurring teachable moments.

- Where review of the records of residents #4, #9, and #11 does not document that the recommendations in their IHPs regarding active treatment are being properly implemented, the QIDP will work with the interdisciplinary team to determine what may be inhibiting full implementation of the active treatment program, and what can be done to ensure that the program is successful going forward. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.
- Where review of the records of residents #4, #9, and #11 indicates that an objective has been achieved or that no progress is being made toward an objective, the QIDP will work with the interdisciplinary team to initiate different interventions to try to achieve the current objective or to move on to the next prioritized objective. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.

#3 Client Protections:

- The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults until all relevant investigations (CIM, APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

- The alleged victim of alleged abuse/neglect will be assessed/treated/monitored by Nursing Staff, the facility ARNP or Physician for any sustained injuries or psychological harm. When appropriate, additional assessment by local hospital personnel will apply. Acute care planning will be initiated for signs and symptoms of psychological harm. Staff will document accordingly. The cottage Psychologist will visit the affected resident(s) and assess for psychological harm. Evidence gathering, photographs and witness statements will be preserved when applicable.

- The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

#4 Abuse of Clients:

- The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults until all relevant investigations (CIM, APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine

**W 102 Governing Body and Management

whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

- The alleged victim of alleged abuse/neglect will be assessed/treated/monitored by Nursing Staff, the facility ARNP or Physician for any sustained injuries or psychological harm. When appropriate, additional assessment by local hospital personnel will apply. Acute care planning will be initiated for signs and symptoms of psychological harm. Staff will document accordingly. The cottage Psychologist will visit the affected client(s) and assess for psychological harm. Evidence gathering, photographs and witness statements will be preserved when applicable.

- The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

How will the facility identify other individuals who have the potential to be affected by the same deficient practices, and how it will act to protect individuals in similar situations?

#1 Maintenance:

- Every month the Facility Services Administrator (FSA) will submit a list of all uncompleted work orders to the CSS Facility and CSS Maintenance Manager. The CSS Facility Manager and CSS Maintenance Manager are required to review and reconcile all uncompleted work orders providing the FSA a time frame as to when the work orders will be completed. If no response is received with the requested time frame the matter will be up channeled to the Superintendent for further action

#2 Active Treatment:

- The IHP for all ICF residents will be reviewed by a QIDP by 4/15/15, regardless of when the resident's next comprehensive annual assessment is due. The QIDP will review each IHP to determine whether it correlates with the resident's comprehensive assessment in regards to the resident's strengths and needs, and if so, whether the IHP describes an active treatment program that can reasonably be expected to enable the resident to function with as much self-determination and independence as possible, and/or to prevent or slow the loss of the resident's current functional status.
- If a resident's IHP indicates that it does not correlate with the resident's strengths and needs as documented in the resident's comprehensive functional assessment, or is otherwise insufficient to enable the ICF to implement an appropriate active treatment program, the reviewing QIDP will arrange for a new IHP to be developed by the IDT as soon as possible.
- If a resident's IHP reasonably correlates with the resident's strengths and needs as documented in the resident's comprehensive assessment, and is either sufficient on its face to enable the ICF to implement an appropriate active treatment program or can be made sufficient with minor modifications, the QIDP will make any necessary modifications and will note in the resident's record that the IHP has been reviewed and approved.
- By 4/15/15, the daily records of a representative sample of all residents whose IHPs have been approved by a QIDP will be reviewed by that staff member to determine whether the active

treatment program for each of those residents has been properly implemented. Review of the records will focus on whether the resident's active treatment program is being implemented both through formal staff interventions and through informal naturally occurring teachable moments.

- If the QIDP finds that the resident's records do not document that the recommendations in the resident's IHP regarding active treatment are being properly implemented, the QIDP will work with interdisciplinary team to determine what may be inhibiting full implementation of the active treatment program, and what can be done to ensure that the program is properly implemented going forward. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.
- If the QIDP finds that the resident's records indicate that an objective has been achieved or that no progress is being made toward an objective, the QIDP will work with the interdisciplinary team to initiate different interventions to try to achieve the current objective or to move on to the next prioritized objective. This discussion and plan will be documented in the resident's records, and any new specific directions for staff will be documented and discussed with all relevant staff who work with the residents.

#3 Client Protection:

- All staff at the Facility is mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff has been retrained to mandatory training requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

- Notify the on-duty authority to ensure continued client(s) protection.
- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU).
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting the time when this occurs.
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.

- Ensure facility procedural incident reporting is followed.

#4 Abuse of Clients:

- All staff at the Facility is mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff has been retrained to mandatory training requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

- Notify the on-duty authority to ensure continued client(s) protection.
- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU).
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting the time when this occurs,
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.
- Ensure facility procedural incident reporting is followed.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not re-occur?

#1 Maintenance:

- The CSS Facility and CSS Maintenance Manager has directed all CSS staff that all completed work orders are to be closed out in AMMS no later than 48 hours upon completion.

- The CSS Facility and CSS Maintenance Manager has directed all CSS staff that upon completion of an urgent repair based on a call-in, they are to contact the PBX switch board, notifying them that the

work has been completed or deferred (providing the reason for deferment). Furthermore, if status notification is not received after 24 hours of the work request, the PBX Chief Operator will contact the CSS Call Center Operator to obtain the status of any uncompleted Urgent Call-In work request and follow-up daily until completed.

- The PBX switch board is the centralized control point for all campus Urgent Call-In work repairs. Additionally, tracking data columns identifying "completion date" and "work verified by" have been added to the Facility Work Order Call Log.

#2 Active Treatment:

- Staff will be trained on the requirements of active treatment. Training will include receipt of specific W Tags and interpretive guidelines.
- The IHP format will be revised and modified to reflect and identify the resident's specific developmental and behavioral management needs.
- The facility will adjust staffing levels and types, including through new hires, wherever a pattern of failure to implement residents' active treatment programs is found to be due to inadequate staffing.

#3 Client Protection:

- The Facility will continue to screen potential employees utilizing the background check (BCCU) process.
- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.
- Laminated copies of Attachment A and B from DDA Policy 5.13 have been prominently placed in cottages and Adult Programs 02/05/15. Attachment A is general definitions of relevant terms, and Attachment B provides clarifying examples of abuse, neglect, financial exploitation, and self-neglect. 02/05/15.
- The Facility will provide DDA Policy 5.13 training at all New Employee Orientations (NEO).
- The Facility will provide DDA Policy 5.13 to all staff annually for continued education. DDA Policy 5.13 Protection Form (DSHS 27-076) "Abuse: Mandatory Reporting" will be signed and uploaded in the employee personnel file.
- The Facility will conduct trend analysis on incident reports related to abuse/neglect, and injuries of unknown origin. When there is a reasonable cause to believe abuse/neglect has occurred or any patterns of injuries identified, further investigation will occur.

**W 102 Governing Body and Management

#4 Abuse of Clients:

- The Facility will continue to screen potential employees utilizing the background check (BCCU) process.
- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.
- Laminated copies of Attachment A and B from DDA Policy 5.13 have been prominently placed in cottages and Adult Programs 02/05/15. Attachment A is general definitions of relevant terms, and Attachment B provides clarifying examples of abuse, neglect, financial exploitation, and self-neglect. 02/05/15.
- The Facility will provide DDA Policy 5.13 training at all New Employee Orientations (NEO).
- The Facility will provide DDA Policy 5.13 to all staff annually for continued education. DDA Policy 5.13 Protection Form (DSHS 27-076) "Abuse: Mandatory Reporting" will be signed and uploaded in the employee personnel file.
- The Facility will conduct trend analysis on incident reports related to abuse/neglect, and injuries of unknown origin. When there is a reasonable cause to believe abuse/neglect has occurred or any patterns of injuries identified, further investigation will occur.

How will the Facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not re-occur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent?

#1 Maintenance:

- The Facility Services Administrator will perform and document a weekly Quality Surveillance Inspection of the PBX Facility Work Order Call Log. Additionally, he will verify a sampling of the previous months completed AMMS work orders and document his findings in a monthly Quality Surveillance Inspection.

#2 Active Treatment:

- Through the QIDP Quarterly Reviews, the QIDP/HPA will provide evidence that the IHP format has been revised to reflect developmental and behavioral management needs. The evidence

will be the revision dates of the objectives within the Monthly Progress Report and the summary in the Quarterly Review.

- ACMs/AP Supervisors will begin monthly spot checks to ensure the Individualized Active Treatment Schedules are consistent with resident objectives and occurring at naturally occurring times. The results of the spot checks will be documented on a facility monitoring tool, and overall findings will be submitted to the QA Committee and the resident's IDT.
- ICF QA Team Committee will discuss findings of spot checks on a quarterly basis.
- If trends or concerns develop from spot checks, the information will be submitted to the RHC Quality Management Coordinator for review and root cause analysis.
- The ICF Administrator will monitor for any patterns of failure to meet active treatment programs and will initiate staff moves or new hires as necessary.

#3 Client Protection:

- As of 2/6/15, the Facility has developed a monitoring tool that will test staffs' understanding of mandatory reporting requirements and the definitions of abuse/neglect. All Attendant Counselor Managers will be trained on the use of the monitoring tool by 02/11/15.
- Attendant Counselor Managers will utilize the tool with all direct reports. This will be implemented for a random sample of staff from three shifts. The Attendant Counselor Managers will be required to complete monitoring of all direct reports within each quarter.
- Psychologists will also utilize the tool to randomly provide spot checks testing of staff knowledge regarding reporting requirements and definitions of abuse/neglect. Psychologists may also be deployed after ACM communication related to additional training needs of specific staff.
- DDA Central Office Quality Assurance will monitor the implementation of the monitoring tool monthly.
- The electronic incident report database was modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian contact. This will allow for enhanced identification of trends. Modification was completed on 02/12/15.
- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.

**W 102 Governing Body and Management

- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.
- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland

#4 Abuse of Clients:

- As of 2/6/15, the Facility has developed a monitoring tool that will test staffs' understanding of mandatory reporting requirements and the definitions of abuse/neglect. All Attendant Counselor Managers were trained on the use of the monitoring tool on 02/11/15.
- Attendant Counselor Managers will utilize the tool with all direct reports. This will be implemented for a random sample of staff from three shifts. The Attendant Counselor Manager will be required to complete monitoring of all direct reports within each quarter. Psychologists will also utilize the tool to test staff knowledge of reporting requirements and definitions of abuse/neglect.
- Central Office Quality Assurance will monitor the implementation of the monitoring tool monthly.
- The electronic incident report database was modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian contact. This will allow for enhanced identification of trends. Modification was completed by 02/12/15.
- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.
- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.

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**W 102 Governing Body and Management

- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland Village.

When will the corrective action be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?

Superintendent/ICF PAT Director/Facility Services Administrator/DDA-1

**W 104 Governing Body (Maintenance and Cleaning)

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- Facility Services did not receive a work request or a call in request to have the drawer repaired for resident #39's dresser drawer. Facility Services will notify CSS to replace the broken drawer.
- Work Orders#1406300144 & 1411050072 was verbally verified as completed by the service provider (CSS) and closed out in AMMS by 2/18/2015.
- Work Order #14110300039 was verbally verified as completed by CSS and closed out in AMMS on 1/15/2015.
- Work Order #14005090038 was verbally verified as completed on 2/6/2015 and closed in AMMS on the same date.
- Work Order #14040700181 was verbally verified as completed on 2/13/2015 and closed in AMMS on the same date.
- Sample Residents #40, #41, #42 all utilize the shower equipment; cleaning schedules will be adhered to after each use to ensure sanitation. Staff will be expected to initial after each resident. Completed 1/15/15.
- Sample Residents #17, #22 utilizes the toilet positioning belt due to poor coordination and seizures, staff will disinfect and clean the device when soiled. Schedule use and monitoring will be identified based on recommendation of professional assessment. Once assessed and if it is determined that continued use is appropriate, the Facility will acquire devices that are FDA approved.
- Sample Resident #35, the soiled gait belt was replaced during at the time of the State Surveyors observation. It will be the expectation that gait belts are utilized during transfers and position and per recommendation from physical therapy. Staff will replace gait belts if soiled. Based on the statement of deficiencies (SOD) completed 01/19/15.
- Wheel chairs will be cleaned when food is spilled onto surfaces by residents. Staff will observe wheelchairs and clean as appropriate.
- Wheel chairs will be inspected on the HS shift and cleaning will occur while residents are sleeping per cleaning schedule.
- Painting of exterior surfaces is part of preventative maintenance provided by Consolidated Support Services (CSS). The painting of Exterior doors and window frames is not considered to place residents at risk. The Facility Services Administrator will coordinate for painting with CSS during the Spring/Summer 2015 to ensure further deterioration is eliminated.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how it will act to protect individuals in similar situations?

B-12

- Every month the Facility Services Administrator (FSA) will submit a list of all uncompleted work orders to the CSS Facility and CSS Maintenance Manager. The CSS Facility Manager and CSS Maintenance Manager are required to review and reconcile all uncompleted work orders providing the FSA a time frame as to when the work orders will be completed. If no response is received with the requested time frame the matter will be up channeled to the Superintendent for further action.
- The Facility will disinfect the gait belts and toilet positioning belts after each residents use and replaced if soiled.
- Shower equipment will be disinfected following each use. Cleaning schedules will be adhered to after each use to ensure sanitation.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur?

- The CSS Facility and Maintenance Manager have directed all CSS staff that all completed work orders are to be closed out in AMMS no later than 48 hours upon completion.
- The CSS Facility and Maintenance Manager have directed all CSS staff that completes Urgent Call-in work repairs are to contact the PBX switch board, notifying them that the work has been completed or deferred (providing the reason for deferment). Furthermore, if status notification is not received after 24 hours of the work request the PBX Chief Operator will contact the CSS Call Center Operator to attain the status of any uncompleted Urgent Call-in work request and follow-up daily until completed.
- The PBX switch board is the centralized control point for all campus Urgent Call-in work repairs. Additionally, tracking data columns identify the completion date and work verified by has been added to the Facility Work Order Call Log.
- Each area that utilizes this type of adaptive equipment will maintain a cleaning schedule to disinfect gait belts and toilet positioning belts after each residents use and replaced if soiled.
- Shower equipment will be disinfected following each use. Cleaning schedules will be adhered to after each use to ensure sanitation.

How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent?

- The Facility Services Administrator will perform and document a weekly Quality Surveillance Inspection of the PBX Facility Work Order Call Log. Additionally, he will verify a sampling of the previous months completed AMMS work orders and document his findings in a monthly Quality Surveillance Inspection.
- ACMs/AP Supervisors will complete quarterly spot checks to ensure cleaning schedules are completed and adhered to and forwarded to the ICF PAT Director

When corrective action will be accomplished?
4/15/2015

AF 15

The title of the person or persons responsible to ensure correction for each deficiency:
Facility Services Administrator, ICF PAT Director

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**W 122-Client Protections

PLAN OF CORRECTION

How will the corrective action be accomplished for the sample individuals found to have been affected by the deficient practice?

The Facility has implemented protective measures for the identified individual by the following:

- The alleged perpetrator was fully reassigned to the [redacted] on January 16, 2015.
- After consultation with the Survey Team the alleged perpetrator was fully reassigned to the [redacted] on January 21, 2015 a position in which she has staff available to ensure supervision at all times.
- A referral related to the incident of alleged abuse was made to [redacted] by the Superintendent on 1/29/15.
- The alleged perpetrator will remain on reassignment with no unsupervised contact with vulnerable adults at Lakeland Village at least until the current investigation by [redacted] is completed.
- The alleged perpetrator was informed of the supervision guidelines contained in the reassignment letter on 01/16/15 and again on 01/21/15.

- The Appointing Authority (Superintendent) has reviewed the Compliance Investigation Manager (CIM) 5-day investigation reports (8/14/14 and 1/23/15) and determined that no other action is needed at this time to protect the identified individual from the alleged perpetrator based on that report. The Appointing Authority notified the guardian on 01/16/15 about the alleged abuse and the actions taken in response.
- The Appointing Authority will take further corrective action related to abuse/neglect if indicated following receipt of the [redacted] investigation.

How will the facility identify other individuals who have the potential to be affected by the same deficient practices, and how it will act to protect individuals in similar situations?

All staff at the Facility are mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff have been retrained to mandatory training requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin will be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

- Notify the on-duty authority to ensure continued client(s) protection.

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- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU).
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting the time when this occurs.
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.
- Ensure facility procedural incident reporting is followed.

The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults until all relevant investigations (CIM, APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

The alleged victim of alleged abuse/neglect will be assessed/treated by Nursing Staff, the facility ARNP or Physician for any sustained injuries or psychological harm. When appropriate, additional assessment by local hospital personnel will apply. Acute care planning will be initiated for signs and symptoms of psychological harm. Staff will document accordingly. The cottage Psychologist will visit the affected client(s) and assess for psychological harm. Evidence gathering, photographs and witness statements will be preserved when applicable.

The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not re-occur?

- The Facility will continue to screen potential employees utilizing the background check (BCCU) process.
- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.
- Laminated copies of Attachment A and B from DDA Policy 5.13 have been prominently placed in cottages and Adult Programs 02/05/15. Attachment A is general definitions of relevant terms,

and Attachment B provides clarifying examples of abuse, neglect, financial exploitation, and self-neglect. 02/05/15.

- The Facility will provide DDA Policy 5.13 training at all New Employee Orientations (NEO).
- The Facility will provide DDA Policy 5.13 to all staff annually for continued education. DDA Policy 5.13 Protection Form (DSHS 27-076) "Abuse: Mandatory Reporting" will be signed and uploaded in the employee personnel file.
- The Facility will conduct trend analysis on incident reports related to abuse/neglect, and injuries of unknown origin. When there is a reasonable cause to believe abuse/neglect has occurred or any patterns of injuries identified, further investigation will occur.

How will the Facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not re-occur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent?

- As of 2/6/15, the Facility has developed a monitoring tool that will test staffs' understanding of mandatory reporting requirements and the definitions of abuse/neglect. All Attendant Counselor Managers were trained on the use of the monitoring tool on 02/11/15.
- Attendant Counselor Managers will utilize the tool with all direct reports. This will be implemented for a random sample of staff from three shifts. The Attendant Counselor Manager will be required to complete monitoring of all direct reports within each quarter. Psychologists will also utilize the tool to test staff knowledge of reporting requirements and definitions of abuse/neglect.
- DDA Central Office Quality Assurance will monitor the implementation of the monitoring tool monthly.
- The electronic incident report database was modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian contact. This will allow for enhanced identification of trends. Modification was completed by 02/12/15.
- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.

**W 122-Client Protections

- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.
- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland Village.

When will the corrective action be accomplished? 4/15/2015

Title of Persons Responsible: Superintendent, ICF PAT Director

**W Tag 125 Exercise of Rights (Views/Beds)

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- For Resident #3, #6, #8, #13, #22, #24, #27,#30,#31,#32,#33, #34, #36, #39, #42, #43, #44, #46
  - The facility has eliminated the practice of blocking clients view from their bedroom windows or cottage living rooms. All painting or window covering that block individual choice to look outdoors have been removed, or altered so viewing outdoors is not impeded. Sample client #24 has made a choice to keep her opaque window covering. Her roommate is moving back to a separate bedroom where windows remain free of obstructions.
- Hi-Lo beds with raised lips are provided to residents. All residents utilizing the raised lip mattresses are able to enter and exit their beds and therefore freedom of movement is not restricted. Physical Therapy or Occupational Therapy will assess individual residents to determine if they are restrictive. If it is determined that the mattress is restrictive an Abridgement of Rights with justification presented to the Human Rights Advisory Committee and consent will be obtained from guardians. All locked doors between cottages will be unlocked or an Abridgement of Rights with justification will be presented to the Human Rights Advisory Committee and consent will be obtained from guardians where a door remains locked. Work orders will be submitted to remove locks on specific cottages that are problematic.
- The IHP's for the sample residents will be reviewed by a QIDP and revised as necessary to ensure that the residents have as much access to their money as possible, based on an individualized determination of the residents' ability to understand and manage money. Residents whose functional assessment indicates that they understand the purpose and process of monetary transactions will have immediate access to their money at all times, and will only be assisted to keep the money safe (e.g., in a locked box in their room). Residents who do not currently understand the purpose and process of monetary transactions will be assisted to gain that understanding, and will have individualized plans for access to their money. That money will in all cases be separately maintained and accounted for.
- Shower handles will be restored to shower areas for access by our resident populations
- Resident #34 will have her personal soda moved to her side of the cottage

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- Attendant Counselor Managers will ensure all window coverings are appropriate and windows will remain free of paint or coverings that impede resident rights to view the outdoors
- Hi-Lo beds with raised lips are provided to residents. All residents utilizing the raised lip mattresses are able to enter and exit their beds and therefore freedom of movement is not restricted. Physical Therapy or Occupational Therapy will assess individual residents to determine if they are restrictive. If it is determined that the mattress is restrictive an

Abridgement of Rights with justification presented to the Human Rights Advisory Committee and consent will be obtained from guardians.

- All locked doors between cottages will be unlocked or an Abridgement of Rights with justification will be presented to the Human Rights Advisory Committee and consent will be obtained from guardians where a door remains locked. Work orders will be submitted to remove locks on specific cottages that are problematic.
- The IHP's for all residents will be reviewed by a QIDP and revised as necessary to ensure that the residents have as much access to their money as possible, based on an individualized determination of the residents' ability to understand and manage money. Residents whose functional assessment indicates that they understand the purpose and process of monetary transactions will have immediate access to their money at all times, and will only be assisted to keep the money safe (e.g., in a locked box in their room). Residents who do not currently understand the purpose and process of monetary transactions will be assisted to gain that understanding, and will have individualized plans for access to their money. That money will in all cases be separately maintained and accounted for.
- Shower handles will be restored to shower areas for access by our resident populations and each individual resident's need for monitoring during showering will be assessed.
- Resident belongings (including personal soda) will be stored in their cottage

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- Attendant Counselor Managers will ensure all window coverings are appropriate and windows will remain free of paint or coverings that impede resident rights to view the outdoors
- Hi-Lo beds with raised lips are provided to residents. All residents utilizing the raised lip mattresses are able to enter and exit their beds and therefore freedom of movement is not restricted. Physical Therapy or Occupational Therapy will assess individual residents to determine if they are restrictive. If it is determined that the mattress is restrictive an Abridgement of Rights with justification presented to the Human Rights Advisory Committee and consent will be obtained from guardians.
- All locked doors between cottages will be unlocked or an Abridgement of Rights with justification will be presented to the Human Rights Advisory Committee and consent will be obtained from guardians where a door remains locked. Work orders will be submitted to remove locks on specific cottages that are problematic.
- The IHP's for all residents will be reviewed by a QIDP and revised as necessary to ensure that the residents have as much access to their money as possible, based on an individualized determination of the residents' ability to understand and manage money. Residents whose functional assessment indicates that they understand the purpose and process of monetary transactions will have immediate access to their money at all times, and will only be assisted to keep the money safe (e.g., in a locked box in their room). Residents who do not currently understand the purpose and process of monetary transactions will be assisted to gain that

understanding, and will have individualized plans for access to their money. That money will in all cases be separately maintained and accounted for.

- Shower handles will be restored to shower areas for access by our resident populations and each individual resident's need for monitoring during showering will be assessed.
- Resident belongings (including personal soda) will be stored in their cottage
- Resident rights will not be violated without due process through assessment, abridgement and consent.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- ACM will conduct a "Housekeeping, Sanitation and Physical Environment Self-Audit" quarterly.
- Human Rights Advisory Committee will maintain a database related to all abridgements of rights and consents.
- The ICF Administrator will work closely with all QIDPs to ensure that all IHPs are reviewed and revised as necessary to ensure that they include an appropriate plan for residents' access to their money, based on the functional level of the resident and the need to safeguard the money.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.

ICF Administrator

**W-127-Protection of Client Rights.

PLAN OF CORRECTION

How will the corrective action be accomplished for the sample individuals found to have been affected by the deficient practice?

The Facility has implemented protective measures for the identified individual by the following:

- The alleged perpetrator (Staff A) was fully reassigned to the [redacted] on January 16, 2015.
- After consultation with the Survey Team the alleged perpetrator (Staff A) was fully reassigned to the [redacted] on January 21, 2015 a position in which she has staff available to ensure supervision at all times.
- A referral related to the incident of alleged abuse was made to [redacted] by the Superintendent on 1/29/15.
- The alleged perpetrator (Staff A) will remain on reassignment with no unsupervised contact with vulnerable adults at Lakeland Village at least until the current investigation by [redacted] is completed.
- The alleged perpetrator (Staff A) was informed of the supervision guidelines contained in the reassignment letter on 01/16/15 and again on 01/21/15.
- The Appointing Authority (Superintendent) has reviewed the Compliance Investigation Manager (CIM) 5-day investigation reports (8/14/14 and 1/23/15) and determined that no other action is needed at this time to protect the identified individual from the alleged perpetrator (Staff A) based on that report. The Appointing Authority notified the guardian on 01/16/15 about the alleged abuse and the actions taken in response.
- The Appointing Authority will take further corrective action related to abuse/neglect if indicated following receipt of the [redacted] investigation.
- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.

How will the facility identify other individuals who have the potential to be affected by the same deficient practices, and how it will act to protect individuals in similar situations?

All staff at the Facility is mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff has been retrained to mandatory training requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible

and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

- Notify the on-duty authority to ensure continued client(s) protection.
- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU).
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting the time when this occurs.
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.
- Ensure facility procedural incident reporting is followed.

The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults at least until all relevant investigations (CIM; APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

The victim of abuse/neglect will be assessed/treated by Nursing Staff, the facility ARNP or Physician for any sustained injuries or psychological harm. When appropriate, additional assessment by local hospital personnel will apply. Acute care planning will be initiated for signs and symptoms of psychological harm. Staff will document accordingly. The cottage Psychologist will visit the affected client(s) and assess for psychological harm. Evidence gathering, photographs and witness statements will be preserved when applicable.

The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

What measures will be put into place or systemic changes made to ensure that the deficient practice will not re-occur?

- The Facility will continue to screen potential employees utilizing the background check (BCCU) process.

- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA

**W 149-Staff Treatment of Clients

Administrative Reviewers will provide a final review of all incident reports to ensure all required fields on the facility incident report, immediate investigation, and administrative review are completed to review and ensure a complete investigation of reported events or incidents and development of a prevention plan if applicable. Administrative Reviewer will ensure that all appropriate notifications have been completed.

- A Superintendent Memo will communicate to all supervisors that procedure revisions have been completed for review and dissemination of information for training to all direct reports

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The Facility DDA 1 will conduct trend analysis on abuse and neglect incidents. The trending will include; staff person, type of injury, alleged abuse/neglect, client to client altercation, shift, applicable notifications and discuss at the monthly ICF QA meeting
- The office of the Appointing Authority will maintain a database that identifies alleged perpetrator(s) involved in alleged abuse/neglect incidents. The data will also track the outcomes of the investigation. This database is operational as of 2/12/2015.
- Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect.

When corrective action will be accomplished? 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?
Superintendent and ICF PAT Director

**W 153 Staff Treatment of Clients

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice

- Resident #2, #13, #14, #26, #28-
- The Facility will ensure that all allegations of mistreatment, neglect and abuse as well as injuries of unknown source are reported immediately to the Superintendent/Designee in accordance with State Law and established procedures.
- By 2/20/2015 Immediate investigators involved in the notification process for sampled residents #2, #13, #14, #26 and #28 will be informed of the deficiency in reporting to the Superintendent/Designee and will be given the written performance expectation of immediately reporting to the Superintendent/Designee for immediate client protection.
- As an employee of Lakeland Village, all staff are responsible to comply with expectations/work instructions; failure to comply will result in disciplinary actions.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- The Facility will ensure that all allegations of mistreatment, neglect and abuse as well as injuries of unknown source are reported immediately to the Superintendent/Designee in accordance with State Law and established Procedures.
- All staff at the Facility are mandatory reporters. This includes contactors, volunteers, interns, and work study students. All Facility staff has been retrained to mandatory reporting requirements on January 26, 27, 28, 29 and February 5 and 6, 2015.
- All Facility staff will immediately report to the Superintendent/Designee every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect of vulnerable adults.
- Injuries of unknown origin will be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time.
- To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:
  Notify the on-duty authority to ensure continued client(s) protection.
  Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Notify the Appointing Authority immediately for any further instructions

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- All staff at the Facility are mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff have been retrained to mandatory training requirements on January 26, 27, 28, 29 and February 5 and 6, 2015.

**W 153 Staff Treatment of Clients

- All Facility staff will immediately report to the Superintendent/Designee every incident of observed, reported, or suspected abandonment, abuse, financial exploitation, neglect of vulnerable adults.
- Injuries of unknown origin will be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time.
- To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:
  Notify the on-duty authority to ensure continued client(s) protection.
  Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
    - Notify the Appointing Authority immediately for any further instructions

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- The Facility DDA 1/Designee will conduct trend analysis on abuse and neglect incidents. The trending will include: staff name and position, type of injury, alleged abuse/neglect, client to client altercation, shift, applicable notifications and discuss at the monthly ICF QA meeting
- Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and involve the RHC Quality Management Coordinator for root cause analysis as needed.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency. Superintendent and ICF PAT Director.

**W 154 Staff Treatment of Clients

Plan of Correction

How will the corrective action be accomplished for the sample individuals found to have been affected by the deficient practice?

- For Residents #13, #14, #25 -The Facility will ensure that all alleged violations are thoroughly investigated related to allegations of mistreatment, neglect and abuse as well as injuries of unknown source by reopening these investigations to include, but not limited to; the Superintendent contacted the Washington State Patrol and received the completed investigation related to resident # 13 and provided it to survey team on 2/11/2015. The alleged perpetrator no longer works with vulnerable adults. The Superintendent will address procedures related to Smoking in Designated areas with all staff. All identified witnesses will be interviewed and if new information is uncovered, the incident will be re-submitted to the CIMS.
- For Resident #16- The alleged perpetrator was fully reassigned to the [redacted] on January 16, 2015.
  - After consultation with the Survey Team the alleged perpetrator was fully reassigned to the [redacted] on January 21, 2015 a position in which she has staff available to ensure supervision at all times.
  - A referral related to the incident of alleged abuse was made to [redacted] by the Superintendent on 1/29/15.
  - The alleged perpetrator will remain on reassignment with no unsupervised contact with vulnerable adults at Lakeland Village at least until the current investigation by [redacted] is completed.
  - The alleged perpetrator was informed of the supervision guidelines contained in the reassignment letter on 01/16/15 and again on 01/21/15.
  - The Appointing Authority (Superintendent) has reviewed the Compliance Investigation Manager (CIM) 5-day investigation reports (8/14/14 and 1/23/15) and determined that no other action is needed at this time to protect the identified individual from the alleged perpetrator based on that report. The Appointing Authority notified the guardian on 01/16/15 about the alleged abuse and the actions taken in response.
  - The Appointing Authority will take further corrective action related to abuse/neglect if indicated following receipt of the [redacted] investigation.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- Staff/Client Assignments with location of staff at time of incident will be provided with the incident report as part of the investigation packet to ensure that there is evidence that all alleged incidents are thoroughly investigated.

All staff at the Facility are mandatory reporters. This includes contractors, volunteers, interns, and work study students. All Facility staff have been retrained to mandatory reporting requirements on January 26, 27, 28, 29 and February 5 and 6, 2015. All Facility staff will report every incident of observed,

**W 154 Staff Treatment of Clients

reported, or suspected abandonment, abuse, financial exploitation, neglect or self-neglect of children and vulnerable adults. Injuries of unknown origin must be investigated if unwitnessed or could not be explained by the client and if the injury raises suspicion of possible abuse and neglect based on the extent, location, number of injuries observed in time or over a period of time. To the extent possible and appropriate to the situation, the reporter will provide immediate protection and safety. Once protection and safety is achieved the reporter will immediately:

- Notify the on-duty authority to ensure continued client(s) protection.
- Provide supervision until the on-duty authority arrives and removes the alleged perpetrator from client care.
- Contact the Complaint Resolution Unit (CRU).
- Notify the Appointing Authority immediately for any further instructions.

The on-duty authority will:

- Escort the alleged perpetrator to the Support Office of the Superintendent (SOS), noting and documenting the time when this occurs.
- Contact law enforcement as applicable.
- Preserve evidence.
- Contact the person's guardian.
- Ensure facility procedural incident reporting is followed.

The Appointing Authority will immediately reassign an alleged perpetrator to a position in which he or she will have no unsupervised contact with any vulnerable adult. The alleged perpetrator will remain in reassignment status with no unsupervised access to vulnerable adults at least until all relevant investigations (CIM, APS, and/or law enforcement) are complete. In the event that there is no final report from the investigating entity, the Appointing Authority will determine whether continued reassignment of the alleged perpetrator continues to be necessary to ensure the safety of vulnerable adults.

The victim of abuse/neglect will be assessed/treated by Nursing Staff, the facility ARNP or Physician for any sustained injuries or psychological harm. When appropriate, additional assessment by local hospital personnel will apply. Acute care planning will be initiated for signs and symptoms of psychological harm. Staff will document accordingly. The cottage Psychologist will visit the affected client(s) and assess for psychological harm. Evidence gathering, photographs and witness statements will be preserved when applicable.

The Appointing Authority will thoroughly review the investigation and take appropriate disciplinary action up to and including termination of employment.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- The Facility will continue to screen potential employees utilizing the background check (BCCU) process.

**W 154 Staff Treatment of Clients

- The Facility trained staff on Developmental Disabilities Administration (DDA) Policy 5.13, "Protection from Abuse: Mandated Reporting". The training was provided by experienced DDA Central Office staff members. The materials were presented by power-point and copies of DDA Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.

- Laminated copies of Attachment A and B from DDA Policy 5.13 have been prominently placed in cottages and Adult Programs 02/05/15. Attachment A is general definitions of relevant terms, and Attachment B provides clarifying examples of abuse, neglect, financial exploitation, and self-neglect. 02/05/15.

- The Facility will provide DDA Policy 5.13 training at all New Employee Orientations (NEO).

- The Facility will provide DDA Policy 5.13 to all staff annually for continued education. DDA Policy 5.13 Protection Form (DSHS 27-076) "Abuse: Mandatory Reporting" will be signed and uploaded in the employee personnel file.

- The Facility will conduct trend analysis on incident reports related to abuse/neglect, and injuries of unknown origin. When there is a reasonable cause to believe abuse/neglect has occurred or any patterns of injuries identified, further investigation will occur.

- Related to statement of the embedded information of a staff smoking on a patio-The Superintendent will send a memo of expectation related to Smoking in Designated Smoking Areas only to all supervisors who will in turn review with all direct reports.

- The Facility will schedule Investigator Training for personnel who conduct incident report investigations by 4/15/2015.

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- As of 2/6/15, the Facility has developed a monitoring tool that will test staffs' understanding of mandatory reporting requirements and the definitions of abuse/neglect. All Attendant Counselor Managers will be trained on the use of the monitoring tool by 02/11/15.
- Attendant Counselor Managers will utilize the tool with all direct reports. This will be implemented for a random sample of staff from three shifts. The Attendant Counselor Managers will be required to complete monitoring of all direct reports within each quarter.
- Psychologists will also utilize the tool to randomly provide spot checks testing of staff knowledge regarding reporting requirements and definitions of abuse/neglect. Psychologists may also be deployed after ACM communication related to additional training needs of specific staff.
- DDA Central Office Quality Assurance will monitor the implementation of the monitoring tool monthly.

Policy 5.13 were provided to all attendees. Training was completed for 740 staff members on 2/6/15.

- Laminated copies of Attachment A and B from DDA Policy 5.13 have been prominently placed in cottages and Adult Programs 02/05/15. Attachment A is general definitions of relevant terms, and Attachment B provides clarifying examples of abuse, neglect, financial exploitation, and self-neglect. 02/05/15.
- The Facility will provide DDA Policy 5.13 training at all New Employee Orientations (NEO).
- The Facility will provide DDA Policy 5.13 to all staff annually for continued education. DDA Policy 5.13 Protection Form (DSHS 27-076) "Abuse: Mandatory Reporting" will be signed and uploaded in the employee personnel file.
- The Facility will conduct trend analysis on incident reports related to abuse/neglect, and injuries of unknown origin. When there is a reasonable cause to believe abuse/neglect has occurred or any patterns of injuries identified, further investigation will occur.
- The Facility will train staff on DDA Policy 5.06-Client Rights to provide the summary of civil rights of eligible residents of the Developmental Disabilities Administration.
- Issues related to Protection of Client Rights will be submitted to Human Rights Advisory Committee for review/discussion and approval/disapproval.

How will the Facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not re-occur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent?

- As of 2/6/15, the Facility has developed a monitoring tool that will test staffs' understanding of mandatory reporting requirements and the definitions of abuse/neglect. All Attendant Counselor Managers will be trained on the use of the monitoring tool by 02/11/15.
- Attendant Counselor Managers will utilize the tool with all direct reports. This will be implemented for a random sample of staff from three shifts. The Attendant Counselor Manager's will be required to complete monitoring of all direct reports within each quarter.
- Psychologists will also utilize the tool to randomly provide spot checks testing of staff knowledge regarding reporting requirements and definitions of abuse/neglect. Psychologists may also be deployed after ACM communication related to additional training needs of specific staff.
- DDA Central Office Quality Assurance will monitor the implementation of the monitoring tool monthly.
- The electronic incident report database was modified to include client, type of injury, alleged abuse/neglect, client to client altercation, shift, complaint resolution notification, and guardian

contact. This will allow for enhanced identification of trends. Modification was completed on 02/12/15.

- The office of the Appointing Authority will maintain a data base that identifies alleged perpetrator(s) involved in abuse/neglect incidents. The data will also track the outcomes of the investigation. This data base is expected to be operational by 02/12/15.
- The Interdisciplinary Team will monitor client to client altercations and recommend changes. This will include the need for environmental modifications, or increase in supervision. Behavior Support Plans (BSP) will be modified with any additional positive approaches/interventions.
- In cases involving alleged abuse/neglect, Licensed Nursing will complete Acute Care Plans for any injuries and establish monitoring criteria for psychological harm. The monitoring will occur for at least 72 hours following incidents that involve alleged abuse/neglect.
- When a client is involved in alleged abuse/neglect incident the Psychologist will review the client unit record (CUR) progress notes and assess the client for signs and symptoms of psychological harm and provide any counselling services when indicated.
- Where data indicates trends of staff alleged abuse/neglect or client to client altercations the Superintendent will call for additional investigation.
- Interdisciplinary Team will identify cottages where client to client altercation or alleged staff abuse/neglect is occurring on a frequent basis and conduct a root cause analysis with the assistance from the RHC Quality Management Coordinator and inform the ICF QA committee.
- The monthly ICF Quality Assurance Committee will include incident trending as a standing agenda item.
- The Human Rights Committee will analyze incident trending data related to client to client altercation and allegations of abuse/neglect and all restrictive practices at Lakeland Village.

When will the corrective action be accomplished? 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency?
Superintendent/ICF PAT Director

**W 130 –Protection of Client Rights

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

- The installation of three privacy curtains in the bathrooms on Pinewood Cottage was completed on 1/14/15. This is not a pervasive issue on campus, however if a privacy curtain is needed it will be replaced immediately.
- Client privacy will be maintained.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- Cottage ACMs and housekeeping staff will spot check cottage privacy curtains.
- This is not a pervasive issue on campus, whenever a privacy curtain is damaged, soiled, or missing it will be replaced immediately.

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- Facility staff will be expected to identify any privacy issues and report findings to the area supervisor so immediate corrections can be made.
- Residential Services Coordinators on shift 2 will complete quarterly monitoring reviews for privacy standards

How will the facility monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.

- ACMs will conduct a "Housekeeping, Sanitation and Physical Environment Self-Audit" quarterly.
- The ICF has developed a QA team/committee with audit tools in which peer review audits will occur on a neighboring cottage at least quarterly.
- The QA team/committee will review the quarterly peer audits to ensure deficiencies are completed in a timely fashion.

When corrective action will be accomplished? 4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency? ICF PAT Director, AC Managers

KLB

**W 148 Notification of Guardian

Plan of Correction

How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice?

Regarding the sampled clients-#2, #13, #14, #15, #16, #25, #26, #29

- Superintendent/ICF PAT Director will inform the parents/guardians of residents 2,13, 14, 15, 16, 25, 26, and 29 about the incidents noted in the Statement of Deficiencies involving those residents by. 2/27/2015.

- The facility will promptly notify parents/guardians of those residents of any significant incidents, or changes in the resident's condition including, but not limited to incidents of serious illness, accident, death, abuse or unauthorized absence.

How the facility will identify other individuals who have the potential to be affected by the same deficient practice and how it will act to protect individuals in similar situations?

- Immediate investigator or designee will immediately attempt to notify the client/resident guardian of any serious incidents or changes in the resident's condition, including but not limited to serious illness, injuring, accident, death, abuse or unauthorized absence. Notification will be documented immediately in the CUR/RUR. The Incident Report will also contain the information related to time, date and name of guardian with whom they spoke. If notification of guardian is not successful the PAT Director or Designee will ensure that attempts to contact guardian are made and documented at least daily until contact is made.
- The Facility has modified the parent/guardian database to include the direction for the immediate investigators to "Notify the guardian of any: Serious incident or changes in resident's condition, including but not limited to serious illness, injury, accident, death, abuse or unauthorized absence."

What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur.

- Immediate Investigators and Administrative Reviewers will be retrained on the revised LV Procedure 10.6B Client/Resident Protection: Immediate Investigators will ensure that resident's parents/guardians will be notified following any serious incident or change in the resident's condition, including but not limited to serious illness, injury, accident, death, abuse or unauthorized absence and documented immediately in the CUR/RUR and Incident Report.
- The Facility has modified the parent/guardian database to include the direction for the immediate investigators to "Notify the guardian of any: substantial injury or any alleged abuse/neglect that has occurred."

**W 148 Notification of Guardian

How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur. (i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent.)

- The ICF/DDA 1 will provide a final review of all I/E Reports to ensure all required fields on the facility incident report, immediate investigation and administrative review are complete to include the documentation of the notification of the guardian.

When corrective action will be accomplished?

4/15/2015

The title of the person or persons responsible to ensure correction for each deficiency.
Superintendent and ICF PAT Director

28 D

(10)(f)(vi) Review the regulation of Continuing Care Retirement Communities and ways to protect those who reside in them, including the consideration of effective disclosure to residents;

- A Continuing Care Retirement Community (CCRC) is considered a person's own residence (independent living) therefore protection of a vulnerable adult living in that setting would fall under the jurisdiction of Adult Protective Services, under 74.34, if a report of abuse or neglect was reported.
- A brief description of Continuing Care Retirement Community (CCRC) is attached.

Overview of Continuing Care Retirement Communities (CCRC)

Residential Care Services (RCS) does not have licensing or oversight authority over Continuing Care Retirement Communities (CCRC). In Washington State, CCRCs are not licensed by any regulatory body.

CCRCs can be located on the same campus as a licensed nursing home or licensed assisted living facility. RCS' licensors/surveyors are mandatory reporters meaning that if they observe or hear of any care issues even those occurring in non-licensed building in the CCRCs, they will call the issue in to the Department's complaint hotline for investigation. In this situation, a CCRC resident is considered a person who is independent living in their own residence so protection of this vulnerable adult falls to the Department's Adult Protective Services.

Adult Protective Services investigate reports of abandonment, abuse, financial exploitation, neglect and self-neglect of vulnerable adults, and provides protective services and legal remedies for this vulnerable population. Chapter 74.34 RCW. is the governing statutory authority for Adult Protective Services.

Attached you will find the section of Chapter 74.34 RCW that defines vulnerable adult and established the legislative need for Adult Protective Services. You will also find a further description of a CCRC.

RCW 74.34.005
Findings.

The legislature finds and declares that:

(1) Some adults are vulnerable and may be subjected to abuse, neglect, financial exploitation, or abandonment by a family member, care provider, or other person who has a relationship with the vulnerable adult;

(2) A vulnerable adult may be home bound or otherwise unable to represent himself or herself in court or to retain legal counsel in order to obtain the relief available under this chapter or other protections offered through the courts;

(3) A vulnerable adult may lack the ability to perform or obtain those services necessary to maintain his or her well-being because he or she lacks the capacity for consent;

(4) A vulnerable adult may have health problems that place him or her in a dependent position;

(5) The department and appropriate agencies must be prepared to receive reports of abandonment, abuse, financial exploitation, or neglect of vulnerable adults;

(6) The department must provide protective services in the least restrictive environment appropriate and available to the vulnerable adult.

[1999 c 176 § 2.]

Notes:

Findings -- Purpose--1999 c 176: "The legislature finds that the provisions for the protection of vulnerable adults found in chapters 26.44, 70.124, and 74.34 RCW contain different definitions for abandonment, abuse, exploitation, and neglect. The legislature finds that combining the sections of these chapters that pertain to the protection of vulnerable adults would better serve this state's population of vulnerable adults. The purpose of chapter 74.34 RCW is to provide the department and law enforcement agencies with the authority to investigate complaints of abandonment, abuse, financial exploitation, or neglect of vulnerable adults and to provide protective services and legal remedies to protect these vulnerable adults." [1999 c 176 § 1.]

Severability -- 1999 c 176: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1999 c 176 § 36.]

Conflict with federal requirements -- 1999 c 176: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [1999 c 176 § 37.]

Continuing Care Retirement Community (CCRC)

A Continuing Care Retirement Community (CCRC) is a residential community for adults that offers a range of housing options (normally independent living through nursing home care) and varying levels of medical and personal care services. A CCRC is designed to meet a resident's needs in a familiar setting as he/she grows older. People most often move into such a community when they're healthy.

A CCRC resident has to sign a long-term contract that provides for housing, personal care, housekeeping, yard care and nursing care. This contract typically involves either an entry fee or buy-in fee in addition to monthly service charges, which may change according to the medical or personal care services required. Fees vary depending on whether the person owns or rents the living space, its size and location, the type of service plan chosen, and the current risk for needing intensive long-term care. Because the contracts are lifelong and fees vary, it is important to get financial and legal advice before signing.

Washington State does not license retirement communities. To find local retirement communities in the area, contact your local Senior Information and Assistance office.

(10)(f)(vii) Identify the needs of older people and people with disabilities for high quality public and private guardianship services and information about assisted decision-making options;

- Residential Care Services (RCS)

(10)(f)(vii) Identify the needs of older people and people with disabilities for high-quality public and private guardianship services and information about assisted decision making options.

Individuals with cognitive impairments require varying degrees of assistance with decision making. At one end of the spectrum are individuals who simply need someone to consult with regarding choices in complex areas, such as money management. At the other end of the spectrum are individuals who lack the cognitive ability to make basic life decisions. As more and more individuals have Alzheimer's disease and other types of dementia, this is becoming a growing issue in terms of decision making. It's currently estimated there are approximately 107,000 people with Alzheimer's or other dementia in Washington State; that number is projected to increase to 271,000 by 2040. For every level of decision-making ability, the assistance provided should be the least intrusive necessary for an informed decision to be made. The goal of all assistance should be to ensure that the individual maintains or achieves the highest level of independence of which he or she is capable.

In Washington, the greatest unmet need related to decision making is the need for more publicly-funded guardians and limited guardians for individuals with significantly impaired capacity and limited financial means. While this is a small minority of the total population of persons with cognitive impairments, the problem for these people is acute. Individuals with financial means or with willing and able family members can obtain guardians when needed, but indigent and isolated individuals have much more difficulty obtaining guardians. The absence of a comprehensive public guardianship system in Washington means that many people who require legally-appointed guardians for some, or all of their decision-making, either go without or are forced to reside in more restrictive settings.

Although many individuals who require guardians receive social security benefits, that funding is generally insufficient to pay guardianship fees on top of normal costs of living (room and board). Washington law prohibits the use of state or county funds to pay guardians (RCW 11.92.180), but individuals who live in facilities in which their costs of living and care are subsidized can have that subsidy increased, leaving money available for the individual to pay guardian fees from his or her personal income. (Such facilities include adult family homes, assisted living facilities, nursing homes, and residential habilitation centers.) However, individuals who live in their own homes, even those who are enrolled in a DSHS-certified supported living program, often cannot obtain a guardian because they have no money to pay a professional guardian and no one willing to provide the service for free.

The lack of guardianship services is particularly problematic for individuals who lack capacity to provide consent for health care and who have no family members able and willing to act as substitute-decision makers, since health care providers are, at best, reluctant to provide care when no one is legally empowered to provide consent. Guardians are also needed for legal and

financial matters that individuals cannot resolve on their own, due to their disability. Considering the growing issue of decision making as it relates to the growth of individuals with Alzheimer's disease and other dementias, the need for assisted decision making and guardianship services will continue to grow.

That said, full guardianship of the person and estate is not the only, or best means, of assistance with decision-making for most people with cognitive disabilities. Other less intrusive methods for helping people with decisions facilitate greater autonomy and community integration. These methods include limited guardianships (making decisions only for certain purposes, such as health care); person-centered planning (a holistic, inclusive service planning model used by the Aging and Long-Term Support and Developmental Disabilities Administrations within DSHS); and the Necessary Supplemental Accommodation policy which requires that all clients of the Developmental Disabilities Administration to have one other person to help them understand and act on notices and information from DSHS. Necessary Supplemental Accommodation is also part of the Aging and Long-Term Support Administration but is an optional choice.

One strategy in the in the new State Alzheimer's Plan is to promote advance care planning and legal/financial planning in early stages of dementia in order to avoid guardianships when possible. And one of the specific recommendations is to expand the authority of the Office of Public Guardianship to assist individuals with planning end of life care and decision-making, and provide funding to meet the need.

Guardianship Fee impacts for Medicaid beneficiaries

The Department's current process of allowing guardian fees as a deduction from participation has significant drawbacks:

- For clients with limited income, such as SSI recipients, it creates a disincentive for guardians to move clients from more restrictive institutional settings because they will not have money to pay guardian fees when they live in the community
- For clients with limited income who live in residential settings, the state does end up paying guardian fees out of state dollars through an exception to rule process.
- Federal regulations have specific caps on income that can be used to pay guardian fees which are not understood or followed by county commissioners who approve guardianship orders. This places the department in the position of having to violate federal regulations or face contempt of court charges.

WINGS Project

The Department sits on the steering committee for the WINGS Project (Working Interdisciplinary Networks of Guardianship Stakeholders) which is funded by a grant awarded to the Washington State Supreme Court, to partner with community stakeholders in establishing

and maintaining a stakeholder group focused on guardianships and other decision-support options. Facilitated by Washington State Administrative Office of the Courts, WINGS Project Workgroups:

- Identify strengths and weaknesses in the state's current approach to adult guardianship and less restrictive decision-making options;
- Address key policy and practice issues;
- Engage in outreach, education and training, including, for example, training on supported decision-making; and
- Serve as an ongoing problem-solving mechanism to enhance the quality of care and quality of life of adults affected, or potentially affected, by guardianship and other decision-making alternatives.

(10)(f)(viii) Identify options for promoting client safety through Residential Care Services and consider methods of protecting older people and people with disabilities from physical abuse and financial exploitation; and

- Residential Care Services (RCS) conducts ongoing survey of facilities and takes enforcement actions

Promoting Client Safety through Quality Assurance

History and Philosophy of Residential CareServices Quality Assurance System:

Residential Care Services (RCS) received 24 month funding (expiring in March 2016) for 6 FTEs from a Centers for Medicare and Medicaid Services (CMS) community living grant in order to develop and implement a structured, comprehensive quality assurance management system. This is the first time RCS has ever had a formal division wide quality assurance system. The development of this system is critical in accomplishing the mission of promoting excellence in RCS. The QA unit is aligned with RCS' objective to have a fair, consistent, and efficient regulatory system that promotes positive outcomes. Continuous quality improvement of core processes and services ensure quality care and life for individuals residing in licensed and certified settings.

QA Unit's Successes to Date:

In its short tenure thus far, the QA unit has accomplished the following tasks:

1. Conducted nursing home Statement of Deficiencies (SODs) review and audited ASPEN, CMS's Nursing Home tracking system data to identify if Statement of Deficiencies were mailed out on time (within 10 days).
2. Conducted audits of adult family home and assisted living facility to review SODs to determine if they met the Principles of Documentation (POD) standards and to determine if SODs were mailed timely.
3. Conducted a review of Adult Family Home licensing files to determine if Criminal Background checks were done during licensed home inspections.
4. Conducted a comprehensive hands-on review of AFH licensing inspections files to determine if licensors followed standard procedures related to licensing inspections.
5. Conducted an audit in the ICF-IID program to determine if surveys were timely and the SOD was done according the Principles of documentation standards.
6. Conducted an audit and re-audit of the Quality Review standard procedures.
7. Completed phase one Customer Service Feedback Initiative.

QA activities resulted in these systemic changes:

After each audit/review, the QA unit makes recommendations based upon the data they have collected. The following are examples of internal process improvements made:

1. Developed reports to track when SODs are mailed out to meet the 10 working day standard by Centers of Medicare and Medicaid Services.
2. Evaluated and updated the curriculum for SOD writing training to ensure content is meeting the needs of field staff.

3. Require SODs to have a quality review using CMS tool prior to being mailed out.
4. Working on developing a consistent statewide filing system for the working and licensing files.
5. Surveyors/licensors spend time in entrance conference with the relevant team explaining what will be communicated so process is less vague.
6. Require training on communication, cultural humility and respect.
7. Training on entrance and exit conferences.
8. Ensure training covers WACs, RCWs for staff.
9. Schedule periodic forums with stakeholders to improve communication, collaboration.
10. Ensure providers have RCS staff numbers to contact for questions.
11. Review and update content on department website.
12. Provide data on common citations to associations.
13. Institute protocol for investigators/providers to solve issues at lowest levels.
14. Encourage provider associations to tell providers to check websites for updates.

What is needed to continue to build upon the success?

Permanent funding from the legislature is requested to maintain the quality assurance system now in place since the grant funding is scheduled to expire in spring of 2016. Continued funding will allow the Quality Assurance Unit to operationalize consistent, measurable quality assurance practices and conduct independent internal reviews to ensure state performance measures and CMS expectations around quality management are consistently met. The QA unit will continue to implement accountability review mechanisms and monitor proficiency improvement plans to prevent the recurrence of repeat audit findings. Ultimately, residents who live in our licensed and certified long-term care settings will also benefit by ensuring the services provided by the division are in compliance with federal, state and agency rules and regulations.

(10)(f)(ix) A description of the method in place to ascertain the outcome of responses to findings.

- Residential Care Services (RCS) conducts follow up visits/revisits to ensure that facilities are in compliance with initial findings. The processes of follow up visits (revisits) is described in Residential Care Services (RCS) policies in (10)(f)(ii).

- Residential Care Services (RCS) Management Bulletin Nursing Home Post Survey Revisit – Standard Operating Procedure 15-016 – March 10, 2015

- Residential Care Services (RCS) Operational Principles and Procedures for Adult Family Homes (AFH) Licensing Inspections – Follow-up Visits – June 2010

- Residential Care Services (RCS) Standard Operating Procedure (SOP) Assisted Living Facility – Revisits – June 2015

- Residential Care Services (RCS) Informal Dispute Resolution (IDR) Operational Principles and Procedures for Nursing Homes, Assisted Living Homes and Adult Family Homes – July 2014

Overview of RCS's Methods to Ascertain Outcome of Responses in Findings

After Residential Care Services (RCS) conducts an inspection or investigation, if there are findings of non-compliance, the provider is cited in writing on the Statement of Deficiencies. RCS conducts follow up contacts to ensure that the provider is back in compliance with the federal/state laws and rules. Follow-ups can be done in three ways: 1) telephone verification; 2) documentation/letter verification or 3) on-site verification.

Assisted Living and Adult Family Home
For assisted living facilities and adult family homes, telephone and document/letter verification is done only when the deficiencies do not have a direct, adverse impact on resident care, when the deficient practice issue is such that there are clear, objective criteria in determining compliance and the provider has a good history of complying with providing care and services to residents. Examples of letter documentation verifying back in compliance include current CPR/first aid cards, tuberculosis testing results, orientation and training checklists and criminal background check results.

On-site verification for assisted living facilities and adult family homes are required for deficiencies with a negative or potentially negative resident outcome and when the documentation or letter verification is not received.

Nursing Home
For nursing homes, onsite revisits are required to occur when there has been enforcement and for all deficiencies cited above Level F during initial and full surveys. Letter/document reviews occur for deficiencies cited Level F or below.

All Provider Types
If providers disagree with the findings, RCS has a standardized process to give providers an opportunity to informally exchange information to dispute violations and enforcement actions. Staff who did not participate in the analysis and oversee the determination of violations and enforcement remedies conducts the informal dispute resolution process.

Attached you will find the standard operating procedures for the nursing home revisits and assisted living and adult family home follow up visits. You will also find the standard operating procedure for the informal dispute resolution process.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
Residential Care Services Division
PO Box 45600, Olympia, WA 98504-5600

RCS MANAGEMENT BULLETIN

15-016 – PROCEDURE
March 10, 2015

TO: RCS Regional Administrators
RCS Field Managers
RCS Management Team
RCS Compliance Specialists

FROM: Carl I Walters II., Director
Residential Care Services

SUBJECT: **NURSING HOME POST-SURVEY REVISIT – STANDARD OPERATING PROCEDURES (SOP) NH**

PURPOSE: To remind survey staff about the formal expectations and procedures to follow for post-survey revisits in nursing homes.

BACKGROUND:
- In June 2013, RCS Management Bulletin R13-029 issued an Operational Principles and Procedures (OPP) for nursing home post-survey revisits.
- Since June 2013, we have become aware there are still some inconsistencies in the implementation of nursing home post-survey revisit processes.
- Preliminary findings from a recent audit reveal that nursing home revisit documentation has not always been completed.

WHAT'S NEW, CHANGED, OR CLARIFIED

This management bulletin supersedes MB 13-029.

To address the above issues, the 2013 OPP for Nursing Home Revisit Survey has been reviewed, updated, and reissued in the newly adopted Standard Operations Procedures (SOP) format.

Highlights include:
- Purpose, scope and type of revisits;
- When revisits must be conducted;
- How many revisits can be conducted; and
- Documentation necessary to verify a nursing home is back in compliance.

ACTION:

RCS Regional Administrators and Field Managers will:
- Review the updated NH Post Survey Revisit SOP immediately and ensure all NH Survey Staff:
  - Review and follow the updated SOP; and
  - Discard all outdated versions of the 2013 "Revisit Survey OPP"

RCS HQ Training Unit is:

- Currently conducting state-wide training sessions on the QIS NH Post Survey Revisit.

RELATED REFERENCES: None

ATTACHMENTS:

1. Instructions for ACO & ASE-Q Exporting / Importing Post-Survey Revisits
2. NH Post-Survey Revisit SOP


R15-016 - Attachment 1 - Instru


R15-016 - Attachment 2 - SOP.c

CONTACT(S): RCS Field Managers

TITLE:	ORIGINATOR:	DOCUMENT ID NUMBER:
Nursing Home (NH) Post Survey Revisit	Policy & Training	*To be issued by Policy Unit*
	SUPERSEDES: June 6, 2013	EFFECTIVE DATE: March 2015

I. PURPOSE

To ensure nursing home (NH) post survey revisits are conducted throughout the state in a consistent manner according to state licensing and federal certification requirements.

II. SCOPE

This procedure involves post survey revisits done in nursing homes after a survey or complaint.

III. OPERATIONAL REQUIREMENTS

A. QIS-post survey revisit is conducted in accordance with section 7317 to confirm that a facility is in compliance and has the ability to manage its residents.

B. Post revisit surveys will be brief, focused, purposeful reviews of previously cited deficiencies to evaluate if correction has occurred.

C. Onsite revisits can be conducted anytime for any level of non-compliance.

D. If a surveyor does not receive credible documentation verifying back in compliance from the facility, they need to consult with Field Manager and discuss an on-site revisit.

E. The Field Manager is responsible for ensuring that:

1. Onsite revisits occur when there has been enforcement and for all deficiencies cited above Level F during initial, full, and complaint surveys.
2. Letter/document reviews or onsite revisits occur, for deficiencies cited at Level F or below. The Field Manager will determine if the revisit should be onsite for non-substandard deficiencies at Level F and below.
3. Telephone interview with follow-up documentation reviews occur, provided the facility can confirm correction in interview and documentation as support.

F. Whenever possible, the post survey revisit should have at least one member from the original survey team.

In order to determine if the facility has the ability to remain in substantial compliance, post survey revisits should not occur during or on the last date for the plan of correction. Correction dates should not exceed forty-five (45) days from the last day of the onsite survey unless the revisit team obtains management approval for an extension *(see Nursing Homes Enforcement Process Plan of Correction SOP for details)*.

G. The field will generally do revisits by day 60, and no later than day 70.

1. The Field Manager must ensure all revisits are conducted no later than 70 days after the last date of onsite survey.
2. The field must notify the Office Chief of Field Operations or designee if these timeframes cannot be met.

H. Issues and areas not previously cited will not be subjected to further review during a revisit without cause. "New" deficiencies may be written during a revisit when an obvious problem is observed. A new deficiency must have demonstrated negative outcome for the resident or be a significant threat to resident health and safety.

I. All new nursing home surveyors will be trained on the post survey revisit procedure during new employee orientation.

J. The Quality Assurance (QA) team will monitor the nursing home post survey revisit business practices to ensure they are being uniformly adhered to.

IV. FORMS AND ATTACHMENTS

1. DSHS 10–207
2. DSHS 10-206
3. CMS 2567B

V. PROCEDURES

A. When there has been enforcement, staff will conduct the post survey revisit any time after receipt of the provider letter indicating compliance, by day 60, if possible, but no later than day 70, unless the Office of Field Operations or designee is notified.

**Examples of this may be for situations where the facility did not give a plan of correction date until after the 70th day (e.g., repair a facility's roof). For surveys with no enforcement, staff will conduct the revisit by day 60 if possible, or no later than day 70.

B. In situations where the facility has had an opportunity to correct, the revisit needs to be completed by day 60. This is because RCS needs to inform CMS if the facility is back in compliance by day 60.

C. Staff will consult with Field Manager before conducting any second or subsequent onsite revisit. Field Manager will then consult with Compliance Specialist who will work to obtain CMS RO approval.

D. The Field Manager will ensure that the post survey revisit is accomplished using one of three methods:

1. Letter/Documentation reviews: Correction of Level D-F (not substandard) deficiencies may be verified by letter with documentation submitted by the provider when:
    a. The deficiencies do not have a direct, adverse impact on resident care; i.e. citations are below level "G".
    b. The facility provides acceptable evidence of compliance, fully addressing necessary actions taken by the facility to correct deficiencies; including how and when the correction was achieved. Examples from the SOM of acceptable evidence include an invoice or receipt, copy of amended bylaws or written policies, sign-in sheets verifying staff participation in in-services training, interviews with more than one training participant about training, contact with resident council when dignity issues are involved.
    c. For letter/documentation reviews, the survey team or Field Manager will ensure that the Back in Compliance (BIC) notice letter is sent to the provider. A copy of this notice letter along with the all the documents submitted by the facility verifying correction are retained in the office facility file.
2. Onsite Revisits: Correction of deficiencies must be verified by an onsite visit:
    a. When the deficiencies have direct impact on resident care; i.e. deficiencies cited above Level F.
    b. For any substandard care, Level F and above.
    c. When the documentation submitted by the provider does not adequately support the conclusion that correction has been achieved.
    d. At the Field Manager's discretion after discussion with the Compliance Specialist.

3. Telephone Interview with documentation reviews.
   a. Correction of the deficiencies may be verified by telephone only under the following situations:
      i. The deficiencies do not have a direct, adverse impact on resident care, e.g. citations are not associated with a negative or potentially negative resident outcome.
      ii. The deficient practice issue is such that there are clear, objective criteria for determining compliance.
      iii. The NH has a good history of compliance with the provision of care and services to residents.
      iv. The surveyor/investigator must document pertinent details of the call to the NH and a statement indicating if the facility was found back in compliance and places the information in the NH facility file along with documents sent by the NH.
   b. The surveyor/investigator must document pertinent details of the call to the nursing home and a statement indicating if the NH was found back in compliance. The information about the call and the documents sent by the nursing home must be place in the office NH facility file..

E. Conduct onsite QIS post survey revisit in accordance with the QIS Post Survey Revisit Procedures and checklist including use of QIS standard survey shell, tablet PC and CMS-2567 with the facility POC.

F. Conduct complaint investigation onsite revisit as follows:
   1. Prepare prior to conducting the revisit, and at a minimum consider the following information:
      a. The provider's compliance history;
      b. All outstanding citations as these should be reviewed at the revisit;
      c. The nature, scope, and severity of each cited deficiency; and
      d. If sanctions were imposed or if they may be imposed against the provider as a result of the revisit.
   2. Discuss a plan or approach for how the revisit will be conducted and help focus the team's work.
   3. Conduct an entrance conference to explain the purpose of the visit and to request any information needed to conduct the revisit.
   4. The nature, scope, and severity of previously cited deficiencies determine the extent of the revisit. Only those survey tasks necessary to ascertain compliance status are required.
   5. Focus the sample selection on residents who are most likely to be at risk of problems/condition/needs cited in any currently open survey.
   6. Determine the sample size using 60% of the sample size for a traditional survey as described in resident sample selection with the following exceptions:
      a. Phase 1 sample size is 60%, or less if appropriate to determine compliance.
      b. Phase 2 sample selection is not required.
   7. Review records and documentation from the last day of the survey to the time of the revisit. However, citations may only be written based on deficiencies existing after the date of facility letter asserting compliance or last day of the plan of correction.

E. Completion of the required forms for all types of revisits:

1. Document if the facility is in compliance with regulations on the CMS 2567B, and the DSHS 10-207.
2. Deficiency(s) remain uncorrected or new citations identified, document on the CMS 2567, and DSHS 10-207.
   a. Update compliance history in ASPEN.
   c. Make changes in ASPEN report, if any, and fax the CMS 2567 to provider, if unable to meet the required revisit timelines.
   d. Mail the original CMS 2567 and DSHS 10-207 with the Field Manager's cover letter to the provider by fax or overnight/certified mail.
   e. Fax alert sheet and above report except DSHS 10-207 form to the Regional Office for the following deficiencies - substandard, immediate jeopardy, harm or third failed revisit.
   f. Conduct 2nd post survey revisit upon receipt of 2nd POC on or before 70th day provided permission is obtained.
   g. Notify via email the Office Chief or designee if revisit is scheduled after 70th day and provide the reason.
   h. Record all time spent on revisit activity on the CMS 670 in ASPEN in accordance with ASPEN time reporting instructions.
3. Process post survey revisit documents completed as the result of a letter/documentation or phone review in the same manner as documentation completed as the result of an onsite revisit.
4. Facility will submit their documentation verifying correction by the latest date on their plan of correction.
5. When all deficiencies have been corrected and no new deficiencies are cited, the administrator's signature is not required on DSHS 10-207, CMS 2567B. The 2567B is an internal document and is not sent to the provider.
6. Within seven working days, send a BIC letter to provider indicating that the facility is in compliance. The BIC letter will be sent from the field unless there is a stop placement that is lifted at the same time. If there is a stop placement lift letter needed, the compliance unit will send the lift stop place letter and include the BIC language The Administrative Assistant will process the packet by making a C&T (CMS-1539), and appropriate data entry in ASPEN/CASPER.

VI. AUTHORITY

1. State Operations Manual (SOM):
   Chapter 7 Section 7317, Chapter 2 Section 2732
   Appendix P: II.A.3.
   (QIS); II.B.3. (complaints)

Carl I Walters II, Director
Residential Care Services

March 10, 2015
Date

Residential Care Services (RCS)
Operational Principles and Procedures for
Adult Family Homes (AFHs)
LICENSING INSPECTIONS

FOLLOW-UP VISITS

I. Purpose

To determine if the home is back in compliance with the state licensing laws and rules cited in any previous inspection or complaint investigation.

II. Authority

RCW 74.39A.060 RCW 70.128.070

III. Operational Principles

The Licensor will:

A. Focus the follow-up visit on the areas of deficient practice previously cited.
B. Not delay the follow-up visit waiting for the Informal Dispute Resolution (IDR) results or an attestation of correction.

IV. Procedure

The Field Manager will:

A. Consult with the Licensor or Investigator to determine if the of follow-up visit will be done by:
   1. Telephone verification;
   2. Documentation/letter verification; or
   3. On-site verification.
B. Track any additional visits/citations once the home is initially out of compliance.
C. Include the person who did the original inspection or complaint investigation in the follow up visit, whenever possible.
D. Generally limit the practice of investigating new complaints during follow-up visits. If possible the follow-up visit should be completed before any new complaint investigation so that the provider is back in compliance before writing new citations.
E. Will notify the Compliance Specialist/Assistant Director to strategize further enforcement action steps if the provider has failed the second follow-up visit.
F. Only schedule a third follow-up visit after consultation with the Compliance Specialist/Assistant Director.

The Licensor will:

A. Make follow-up visits within 10 to 15 days after the last date on the Plan of correction (POC) that the provider has indicated for compliance.
B. During the follow-up visit only review information from the time period between the last date on the attestation of correction and the date of the follow-up visit to determine if the deficient practice has been corrected and the home is back in compliance.

C. Conduct the on site follow-up visit:
   1. Consider the following prior to the follow-up visit:
      a. Current deficient practice issues, including the nature, scope (number of residents impacted or potentially impacted) and severity (seriousness or extent of the impact or potential seriousness or extent of the impact on residents) of each cited deficiency; and
      b. The enforcement remedies imposed as a result of the inspection.
   2. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.
   3. Focus the sample selection on residents who are most likely to be at risk of problems/conditions/needs resulting from the deficient practice cited in the original report.
   4. Only review evidence obtained between the provider's last date on the Attestation and the date of the revisit to make compliance decisions.

D. Upon completion of all follow-up visits:
   1. Record corrected and new or uncorrected deficiencies in FMS.
   2. Write a new Statement of Deficiencies for any new or uncorrected deficiencies.
   3. Process telephone, letter or document review follow-up visits in the same manner as an on-site follow-up visit.
   4. After the telephone call, letter, or document review determine if there is enough information to correct deficiencies, or to recommend to the manager that an on-site follow-up be conducted.
   5. Follow the appropriate tasks of the inspection process necessary to determine home compliance.
   6. Follow the decision making and Statement of Deficiency writing processes for any follow-up visit that results in uncorrected deficiencies.
   7. Follow the FMS processes necessary to schedule and complete the follow-up visit.

Information and Assistance

A. General:
   1. Citing additional issues not cited in the original visit should be a rarity and cited only following consultation with the Field Manager.
   2. Base the sample size on the deficient practice cited and the number of residents necessary to review in order to determine compliance. (You will likely need to include more than one resident in the sample in order to have enough information to determine compliance.)
   3. In order to be efficient, you will only complete the inspection tasks related to the deficient practice: i.e. focused preparation, entrance, focused tour, and focused observations and interviews.

B. Failed follow-up visit:
   1. When the first follow-up visit results in any deficiency the field will complete a second follow-up visit before day 90.

C. Telephone verification. Correction of the deficiencies may be verified by telephone when:
   1. The deficiencies do not have a direct, adverse impact on resident care, i.e. citations are not associated with a negative or potentially negative resident outcome;
   2. The deficient practice issue is such that there are clear, objective criteria for determining compliance;
   3. The provider has a good history of compliance with the provision of care and services to residents; and
   4. Place a note recording the pertinent details of the telephone conversation in the facility file.

D. Documentation/letter verification. Correction of deficiencies may be verified by letter or documentation submitted by the provider when:
   1. The deficiencies do not have a direct, adverse impact on resident care, i.e. citations are not associated with a negative or potentially negative resident outcome;
   2. The home sends a letter that fully addresses the necessary actions taken by the home to implement the correction, whether their plan(s) worked and how and when correction was achieved; and
   3. The home sends copies of documents as verification, i.e. cardiopulmonary resuscitation/first aid cards, tuberculosis test results, orientation checklists, criminal background check results.

      a. Place documentation in the facility file.

E. On site verification. Corrections of deficiencies must be verified by an on-site visit:
   1. For deficiencies with a negative or potentially negative resident outcome;
   2. When the documentation submitted by the provider does not adequately support the conclusion that correction has been achieved; and
   3. At the manager's discretion.

Joyce Pashley Stockwell

Joyce Pashley Stockwell, Director
Residential Care Services

June 30, 2010
Date

TITLE: **ALF INSPECTION: REVISITS**	ORIGINATOR: RCS Policy Unit	DOCUMENT ID NUMBER: *To be issued by Policy Unit*
	SUPERSEDES: ALF Full Inspection OPP: Revisits dated January 2014	EFFECTIVE DATE: June, 2015

I. PURPOSE

To determine if the assisted living facility (ALF) is back in compliance with the state licensing laws and rules cited in any previous inspection or complaint investigation.

II. SCOPE

Revisits

III. OPERATIONAL REQUIREMENTS

A. Revisit inspections will be brief, focused and purposeful reviews of previously cited deficiencies to evaluate if correction has occurred.

B. Do not delay the revisit waiting for the Informal Dispute Resolution (IDR) results or an attestation of correction.

IV. FORMS AND ATTACHMENTS

1. N/A

V. PROCEDURES

THE FIELD MANAGER WILL:

A. Consult with the Licensor or Investigator to determine if the revisit will be done by:
   1. Telephone verification
   2. Documentation/letter verification; or
   3. On-site verification.

B. Track any additional visits/citations once the ALF is initially out of compliance.

C. Include at least one person who did the original inspection or complaint investigation in the revisit, whenever possible.

D. Generally limit the practice of investigating new complaints during revisits. If possible, the revisit is completed before writing new citations.

E. Notify the Compliance Specialist/Chief of Field Operations to strategize further enforcement action steps if the ALF continues to be out of compliance at the second revisit.

F. Only schedule a third revisit after consultation with the Compliance Specialist/Chief of Field Operations.

THE LICENSOR WILL:

A. Make revisits within 10 to 15 days after the last date of the attestation of correction that the ALF has indicated for compliance. Correction dates should not exceed forty-five (45) days since the last day of the onsite visit, even if the attestation statement was not submitted and is part of an informal dispute resolution request.

B. During the revisit only review information from the time period between the last date on the attestation of correction and the date of the revisit to determine if the deficient practice has been corrected and the ALF is back in compliance.

C. Conduct the onsite revisit:
   1. Considering the following prior to the revisit:
      a. Current deficient practice issues, including the nature, scope (number of residents impacted or potentially impacted) and severity (seriousness or extent of the impact or potential seriousness or extent of the impact on residents) of each cited deficiency; and

b. The enforcement remedies imposed as a result of the inspection.

2. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.
3. Focus the sample selection on residents who are most likely to be at risk of problems/conditions/needs resulting from the deficient practice cited in the original report.
4. Only review evidence obtained between the ALF's last date on the attestation and the date of the revisit to make compliance decisions.

D. Upon completion of all revisits:

1. Record corrected, and new or uncorrected deficiencies in FMS.
2. Write a new Statement of Deficiencies for any new or uncorrected deficiencies.
3. Process letter or document review revisits in the same manner as an on-site revisit.
4. After the letter, or document review, the licensor will determine if there is enough information to correct deficiencies, or to recommend to the manager that an on-site revisit be conducted.
5. Follow the decision making and Statement of Deficiency writing processes using Principles of Documentation for any revisit that results in uncorrected deficiencies.
6. Follow the FMS processes necessary to schedule and complete the revisit.

VI. INFORMATION AND ASSISTANCE

A. General:

1. Citing additional issues not cited in the original visit should be rare and cited only following consultation with the Field Manager.
2. Base the sample size on the deficient practice cited and the number of residents necessary to review in order to determine compliance. (You will likely need to include more than one resident in the sample in order to have enough information to determine compliance.)
3. In order to be efficient, you will only complete the inspection tasks related to the deficient practice: e.g. focused preparation, entrance, focused tour, and focused observations and interviews.

B. Failed revisit:

1. When the first revisit results in any deficiency, the field will complete a second revisit before day 90 from the exit date.

C. <u>Telephone only verification:</u>

1. Correction of the deficiencies may be verified by telephone only under the following situations:
   a. The deficiencies do not have a direct, adverse impact on resident care, e.g. citations are not associated with a negative or potentially negative resident outcome;
   b. The deficient practice issue is such that there are clear, objective criteria for determining compliance; and
   c. The ALF has a good history of compliance with the provision of care and services to residents.
2. The licensor must document pertinent details of the call to the ALF and a statement indicating if the facility was found back in compliance and places the information in the ALF file along with documents sent by the ALF.

D. <u>Documentation/Letter verification</u>:

1. The licensor will call the ALF and have a dialogue if/when it may be appropriate to do compliance verification. The licensor can specify what may be acceptable to send in as evidence.

2. The ALF must submit letter/documentation for each deficiency to show they are back in compliance. This letter or documentation verification must fully address for each deficiency cited, the actions the provider has taken to implement the correction, whether the plan worked, when the correction was achieved and how correction will be maintained. This documentation must be submitted on or before the attested plan of correction date.
3. Correction of the deficiencies may be verified by letter or documentation submitted by the ALF when:
   a. The deficiencies do not have a direct, adverse impact on resident care, e.g. citations are not associated with a negative or potentially negative resident outcome. The deficient practice issue is such that there are clear, objective criteria for determining compliance.
   b. The ALF has a good history of compliance with the provision of care and services to residents.
   c. The ALF sends evidence of compliance, fully addressing necessary actions taken by the facility to correct deficiencies; including how and when the correction was achieved. Examples of evidence may include documents, such as cardiopulmonary resuscitation/first aid cards, tuberculosis test results, orientation checklists, criminal background check results.
4. The inspection team reviews ALF documentation and calls the ALF Administrator or designee to discuss the issues in order to determine if sufficient documentation is present to justify reporting the deficiency as corrected, or to recommend to the Field Manager that an onsite revisit inspection be conducted.
5. The inspection team documents pertinent details of the call to ALF and a statement indicating if the ALF was found back in compliance and places the information in the facility file along with documents sent by the facility.

E. On-site verification: Corrections of deficiencies must be verified by an on-site visit:

1. If documentation or letter verification of correction was not received;
2. For deficiencies with a negative or potentially negative resident outcome;
3. When the documentation submitted by the ALF does not adequately support the conclusion that correction has been achieved;
4. After a finding of a violation for which a stop placement has been imposed, within 15 working days from the request for revisit;
5. For violations that are serious or recurring or uncorrected following a previous citation, and create actual or threatened harm to one or more residents' well-being, including violations of resident's rights as soon as appropriate to ensure correction of violation; and
6. At the manager's discretion.

VII. AUTHORITY

1. RCW 18.20.110
2. RCW 74.39A.060

Kathy Morgan, Interim Director
Residential Care Services

June 29, 2015
Date

Residential Care Services
Informal Dispute Resolution
Operational Principles and Procedure
for
Nursing Homes, Assisted Living Homes, and Adult Family Homes

I. Purpose

To make available to Residential Care Services (RCS) guidance and direction to carry out Federal and State statutory requirements in the performance of an informal dispute resolution review (IDR).

To create a standardized process RCS can implement to give providers of licensed and/or certified residential care settings of nursing homes (NH), assisted living homes (ALF), and adult family homes (AFH) an opportunity to informally exchange information to dispute violations and enforcement action issued by RCS.

II. Authority

Adult Family Home	Assisted Living Facility	Nursing Home
RCW 70.128.163	RCW 18.20.195	RCW 18.51.060
RCW 70.128.167	WAC 388-78A-3210	WAC 388-97-4420
WAC 388-76-10990	WAC 388-110-280	42 CFR 488.331
		SOM 7212.1-4

III. Operational Principles

A. Residential Care Services has a standardized, objective informal dispute resolution process for AFH, ALF, and NH. The process is centralized and implemented at RCS headquarters in Lacey.

B. Employees who did not participate in analysis and oversee the determination of violations and enforcement remedies will conduct IDRs.

C. The state is responsible and accountable for IDR decisions.

D. The IDR process is consistent with federal and State Operational Manual (SOM) requirements for nursing homes.

E. An IDR is an informal process for providers. If a provider wants an attorney to attend in person or by phone, they must first inform the IDR Program Manager.

F. Providers may request an IDR review after any federal NH survey and for any licensing or complaint investigation in state licensed ALF and AFH, including enforcement action.

G. The Division does not routinely conduct an IDR for every violation and enforcement action.

H. To informally dispute a violation and/or enforcement action, including consultation in ALFs and AFHs, providers must request an IDR.

I. State and federal law requires all IDR requests must be submitted in writing.

J. The Division will inform the Long Term Care Ombuds Program (LTCOP) of IDR requests and final outcomes. The LTCOP will facilitate any resident's or resident representative's input on the disputed deficiency citation(s).

K. Providers may submit information for review. RCS will only review relevant information which is detailed, paginated, and documented per citation. Irrelevant information not linked to the citation may not be reviewed.

L. Providers must:

- Request an IDR within 10 working days of receipt of the Statement of Deficiency (SOD) report for ALFs and AFHs, and 10 calendar days for NHs.
- Return their Plan of Correction and/or attestations within 5 days of receipt of amended SOD reports for any IDRs that result in modified or deleted violations.

M. Providers will have up to two hours to present in an IDR.

N. The Division will notify providers of final IDR outcomes by letter generally two to three weeks after the IDR. The IDR Program Manager may make courtesy calls to the provider if this timeline has to be extended and/or with the final IDR outcome.

O. The IDR process will not review:

- Scope and severity assessments of deficiencies with the exception of substandard care and immediate jeopardy in NHs
- Survey, inspection, complaint investigation, or IDR operational processes
- Inconsistency in process as perceived by provider
- The acceptability or authority of state and federal laws and regulations
- Timelines and outcome of enforcement actions
- Division concerns other than the disputed violations and/or enforcement
- Complaints about field staff

P. The Division will issue an amended copy of SOD reports if violations are modified and/or deleted.

Q. The Division will issue an amended copy of formal notice letters if enforcement remedies are modified or rescinded.

R. All IDR files and provider submitted requests and information shall meet state and federal public disclosure and patient confidentiality laws and requirements.

S. Timelines identified within this OPP may be extended with Division approval, except as otherwise specified in statute or regulation.

T. Failure to complete an IDR in a timely manner will not delay the effective date of any enforcement action(s).

U. Providers have one opportunity to IDR with no re-reviews, except as provided in the OPP. Additional IDRs may be requested for revisit violations for continuation of the same violations cited, a new deficiency, or new violations resulting from the IDR.

IV. Operational Procedures

IDR Process

Step 1. Notice of IDR Appeal Rights

1. The notice:
   - Explains provider rights to an IDR review;
   - Indicates the method(s) of the IDR process providers may request: direct (face-to-face), telephone, or documentation review;
   - Provides the request submission timelines providers must follow in sending in their request; and
   - Instructs providers to:
     - Make a written request and specify what violations/findings/ enforcement action(s) are disputed and why; and
     - Send their requests to the Division IDR Program Manager at the Olympia address.
2. The field and Division gives providers written notice of IDR appeal rights in a:
   - Notice of violations without enforcement letter that the field mails out with the associated statement of deficiency (SOD);
   - Formal notice of violations with enforcement letter the Division mails out with the associated SOD.
3. Providers will submit written IDR requests (as directed in Department letters that accompany the mailed SOD) to IDR Program staff per mail, email, or fax within 10 days of receipt of the SOD report (10 working days for ALFs and AFHs and 10 calendar days for NHs) that:
   - Identify the citation and/or enforcement action(s) that is disputed;
   - Explain why the home is disputing the action; and
   - Indicate the method of dispute resolution process preferred (direct meeting, telephone conference, or documentation review).

Step 2. Request Receipt

1. The field will instruct providers to contact the IDR Program staff regarding IDR request inquiries and reference the SOD report cover letters for IDR instructions.

2. IDR Program staff will:

- Identify the violation(s), findings, and/or enforcement action(s) in dispute;
- Process the request; and
- Open a hard copy temporary holding IDR file that will contain:

    - Written provider IDR request
    - Disputed SOD report, sample resident/staff identifier list, Form 10-207 crosswalk (NH only)
    - Provider submitted information
    - IDR communication log
    - Applicable enforcement formal notices
    - Applicable amended SOD report and enforcement formal notice letters

Step 3. Scheduling

1. IDR Program staff will:

- Verify the method of IDR provider requested;
- Clarify what violation(s), findings, and/or enforcement action(s) are disputed;
- Schedule the IDR time, date, and conference room;
- Identify who will participate;
- Identify if the provider is going to submit and/or present additional documentation for review and request it be limited in volume and only relevant to the disputed violation(s);
- Send the provider a written notice (per letter, email, and/or fax) confirming date, time, and method of IDR, with cc copies (per email/fax) to the LTCOP and field offices;
- Scan the Field Manager the Provider's IDR request letter identifying what is being disputed and reasons why, if included.
- Enter scheduling data into application FMS and ASPEN programs' tracking systems; and

(If a scheduling delay is confirmed, IDR Program staff will record on the IDR communication log the reason. If delay request is not ruled reasonable as above, proceed with denial of the IDR).

2. The field will:

- Instruct providers to contact the IDR Program staff regarding any IDR scheduling inquiries or changes and to reference SOD cover letters for IDR instructions.
- File a copy of the provider scheduling letter.
- Scan the working papers related to the disputed violations and/or enforcement.

Step 4. Preparation

1. Providers may submit information to IDR Program staff before the IDR, however it is not required.

2. The field will forward any information the provider submitted for IDR to IDR Program staff, and assist with obtaining any information needed for preparation.

3. IDR Program staff may review the following before the scheduled IDR:

- Method of IDR provider requested;
- Compliance history;
- SOD, findings, and/or enforcement action(s) under dispute;
- IDR temporary holding file contents; and
- Any applicable laws and CFRs, RCWs, WACs, and OPPs.

Step 5. Informal Review

1. Providers present their disputable facts.

2. The field will instruct providers to contact the IDR Program staff regarding IDR informal meetings, and supply to the IDR Program staff any facts they want reviewed in the documentation review.

3. IDR Program staff will:

- Facilitate the informal review meeting, encouraging providers to present their disputed facts;
- See the provider understands the purpose of the review, the dynamics of the meeting, two hour time limits, and when to expect receipt of the final outcome notice letter (in most cases, two to three weeks after the review);
- See that the State and provider each have the opportunity to ask and clarify questions;

- Listen and clarify the disputable facts presented;
- Not determine or discuss final outcomes during meeting;
- Not engage in discussions about provider disagreement related to:
  - Scope and severity assessments of deficiencies with the exception of substandard care and immediate jeopardy in NHs;
  - Survey, inspection, complaint investigation, or IDR process;
  - Process inconsistency;
  - State and federal laws and regulations acceptability or authority;
  - Complaints about field staff
  - Timelines and lifting of enforcement actions; and
  - Division concerns other than the disputed violations and/or enforcement.

Step 6. Analysis

1. IDR Program staff may contact the provider or the field seeking additional clarification.

2. The field will route any information needed to Compliance Program staff for analysis.

3. IDR Program staff will:
   - Review provider statements that may result in amendments of violations and/or enforcement remedies;
   - Discuss with the field facts the provider presented that may result in amendments;
   - Review field working papers and QIS (NH only) if necessary; and
   - Discuss disputed violations, findings, and enforcement remedies with compliance specialists.

Step 7. Decision-making

1. The field will route any information needed to IDR Program staff during decision-making.

2. IDR Program staff will:
   - Discuss with the Assistant Director facts from the analysis that may result in amendments in enforcement action.
   - Make the final decision when there are no changes (including no changes to enforcement action); and
   - Discuss the IDR findings with the field as necessary to clarify findings, determine IDR outcomes and whenever there will be changes made to the SOD.

- Inform the field about the final IDR outcome.

3. The Assistant Director will make the final decision(s) for any changes to enforcement action(s) resulting from an IDR.

Step 8. Outcome Notice

1. The field will instruct providers to contact the IDR Program staff regarding IDR provider inquiry about final IDR outcomes.
2. IDR Program staff will:
   - Coordinate with compliance specialists for joint outcome notice letters if changes are made with enforcement (hybrid form of IDR outcome letter and enforcement formal notice letter);
   - Make the changes to SOD reports in FMS/ASPEN;
   - Amend SOD cover letters for any changes to consultation, or any violations changed to a consultation (ALFs and AFHs only);
   - Send the provider an outcome notice letter that may include:
     - No change to violations;
     - No change to violations and enforcement remedies;
     - Change to violations;
     - Change to violations and enforcement remedies;
   - Send providers a new copy of amended SOD/2567/WAC reports and formal notice letters (hybrid form), including amended Form 10-207 (NH WAC crosswalk);
   - Enter the results of the IDR in FMS and ASPEN;
   - Email the field a copy of the IDR outcome letter for ALFs and AFHs, and where to locate the letter in ASPEN for the NHs; and
   - Email the LTCOP a copy of the IDR outcome notice (notice to CMS as applicable for NH).

Step 9. Closure

1. The field will:
   - File their copy of the IDR outcome letter, any amended SOD/2567/WAC reports and Form 10-207s;
   - Follow-through with provider to see the POC (NH only) and attestation dates (ALFs and AFHs only) are transferred over to any amended SOD reports and amended documents signed; and
   - Refer any provider questions about IDR outcome back to IDR Program staff.

2. IDR Program staff will:
    - File the IDR request, schedule letter, IDR outcome notice letters, and any amended SOD reports, cover letters, and amended hybrid enforcement formal notice letters in the central files.

Process Outliers

Withdrawal

1. The field will instruct providers to contact the IDR Program staff regarding notice of withdrawal.
2. IDR Program staff will:
    - Process any withdrawal notices including acknowledgement and confirmation with the provider;
    - Clarify the withdrawal request to rule out any processing problems;
    - Document the withdrawal request on the IDR communication log, if confirmed;
    - Notify field, LTCOP, compliance staff, and CMS (if applicable) of the withdrawal;
    - Enter withdrawal in program applications (ASPEN and SHAREPOINT); and
    - Close out the temporary holding IDR file.

Denial

1. IDR Program staff will:
    - Process any denial notices including acknowledgement and clarify request being beyond submission timeframe;
    - Check ASPEN, FMS, and postal system for dates to confirm denial timeframe per RCS principle;
    - Inform provider by telephone that their request for an IDR has been denied and mail a subsequent denial letter;
    - Distribute denial letter to field, LTCOP, central files; and
    - Notify CMS (if applicable) of the denial.
2. The field will instruct providers to contact IDR Program staff regarding any denials.

Repeat IDR Request

The field and IDR Program staff will inform providers requesting repeat IDRs on the same violation(s) and/or enforcement action(s) that providers are given one opportunity to dispute.

Tracking

IDR Tracking Logs

IDR Program staff will enter IDR data elements into the tracking log(s) upon closure of the IDR process (FMS database for AFH and ALF IDRs and ASPEN for NH IDRs). IDR data elements from all programs will be entered into the IDR Tracking Tool (SHAREPOINT).

Carl I Walters II, Director
Residential Care Services

July 5, 2014
Date