

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

PRINTED: 06/08/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKELAND VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>S 2320 SALNAVE RD, PO BOX 200</b> <b>MEDICAL LAKE, WA 99022</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D 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 revisit Survey to determine abatement of an Immediate Jeopardy (IJ) conducted at Lakeland Village between 3/22/16 through 3/23/2016. The revisit determined the IJ had been abated and the standard at W104 was found back in compliance. The Statement of Deficiencies was revised to remove the citation at W104.  The survey was conducted by: Gerald Heilinger Shana Privett Olivia St. Claire  The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504  Telephone: (360) 725-3215	{W 000}			
{W 108}	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 safety.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure emergency exit signs were posted in the Chapel. This failure put all Clients and staff at risk of not exiting the	{W 108}			

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 108}	Continued From page 1 building safely during an evacuation drill or actual emergency.  Findings include:  Observation on 3/3/16 at 10:08 AM inside the Chapel revealed no emergency exit signs over the two visible exterior doors.  Phone interview on 3/3/16 at 11:51 AM with the Deputy State Fire Marshall revealed emergency exit signs should be in place if the building has two or more exit doors.  Phone interview on 3/4/16 at 1:38 PM with the Deputy State Fire Marshall revealed the State Fire Marshall Department does not walk through building areas such as the Chapel since this is the responsibility of the local Fire Department. The Deputy State Fire Marshall directed the surveyor to Life Safety Code regulation 7.10.1.2 for further review.  Record review on 3/7/16 of Life Safety Code (National Fire Protection Association (NFPA) 101) Section 7.10.1.2 states: " Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. "	{W 108}			
{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	{W 125}			

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{W 125}	<p>Continued From page 2</p> <p>to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to: 1. Have the phone number for the State Survey Agency Complaint Resolution Unit (CRU) phone number posted in a common area in 9 of 10 cottages where clients and/or their families could view it; 2. Have consents for restricting grooming supplies for 2 of 13 Sample Clients (Client #3 and Client #9) and 1 of 11 Expanded Sample Client (Client #14); 3. Have consents to restrict Clients' access to laundry supplies in 1 of 10 cottages; 4. Have consents in place for Client #1 for administering psychoactive medications. These failures prevented the Clients' and visitors from knowing how to file a complaint or a concern with the State Survey Agency without going through the facility's staff, prevented Clients from having free access to their personal grooming supplies and household items and resulted in Client #1 receiving psychoactive medications without proper consent.</p> <p>Findings Include:</p> <p>1. A. Observation on 3/2/16 at 2:25 PM and 3/3/16 at 8:58 AM at Bigfoot Cottage revealed the CRU phone number was not posted in any of the common areas of the cottage where it could be seen by Clients or visitors.</p> <p>Interview on 3/4/16 at 3:25 PM with Staff L verified the only postings of the CRU telephone number in Bigfoot Cottage was under other papers on a bulletin board out of view of clients and visitors. The number did not have an explanation about the right to report abuse, neglect and mistreatment or what the initials CRU</p>	{W 125}		

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{W 125}	<p>Continued From page 3</p> <p>meant. It only listed the telephone number with the acronym CRU.</p> <p>B. Observation on 3/1/16 at 11:05 AM at Cascade Cottage revealed the CRU phone number was posted on a thin piece of pink paper in the kitchen. The CRU hotline number was not clearly visible to the clients and visitors.</p> <p>Interview on 3/3/16 at 10:35 AM with Staff I verified the CRU hotline phone number was not clearly posted for clients and /or visitors to view.</p> <p>C. Observation on 2/29/16 at 2:42 PM at Sunrise 82/83 Cottage revealed the CRU phone number was not posted in any of the common areas of the cottage where it could be seen by clients or visitors.</p> <p>Interview on 3/3/16 at 2:10 PM with Staff M verified the CRU hotline phone number was not posted in any common areas of the cottage for clients and /or their families to view.</p> <p>D. Observation on 2/29/16 at 10:58 AM at Pinewood Cottage revealed the phone number for CRU was not posted in any common areas frequented by clients and visitors.</p> <p>Interview on 3/2/16 at 9:56 AM with Staff B revealed the CRU phone number was posted in the office hallway area that connects the two kitchens. This area is not commonly used by clients or visitors.</p> <p>E. Observation on 2/29/16 at 1:38 PM at Hillside Cottage revealed the phone number for CRU was not posted in common areas frequented by clients and visitors.</p>	{W 125}		

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{W 125}	Continued From page 4  Interview on 3/3/16 at 9:40 AM with Staff C revealed the CRU phone number in the office hallway area that connects the two kitchens. This area is not commonly used by clients or visitors.  F. Observation on 2/29/16 at 10:45 AM at Willow Cottage revealed the CRU phone number was not posted in the cottage.  Interview on 3/3/16 at 2:45 PM with Staff S verified there were no postings of the CRU number.  G. Observation on 3/1/16 at 7:20 AM at Apple Cottage revealed the CRU phone number was posted in the kitchen but it was in small letters by the phone and did not have an explanation as to what the number was for.  Interview on 3/3/16 at 2:56 PM with Staff T verified the posting of the CRU number was not prominent and did not explain the purpose of the number.  H. Observation on 3/1/16 at 9:00 AM at Sunrise 84/85 Cottage revealed the CRU phone number was not posted in the cottage.  Interview on 3/03/16 at 9:00 AM with Staff W verified there were no postings of the CRU number.  I. Observation on 3/01/16 at 9:45 AM at Wildrose Cottage revealed the CRU phone number was not posted in the cottage.  Interview on 03/03/16 at 11:00 AM with Staff F verified there were no postings of the CRU	{W 125}		

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{W 125}	<p>Continued From page 5 number.</p> <p>2. Observation on 2/29/16 at 1:35 PM at Evergreen Cottage revealed bathroom grooming areas on both sides of the cottage had clear plastic locked boxes above the sink areas that held the Clients' toothbrushes, electric razors, toothpaste and mouthwash. Further inspection revealed other locked cabinets in both bathroom/grooming areas containing Clients' shampoos, lotions, deodorant, colognes, after shave, hair barrettes, conditioner, etc.</p> <p>Record review on 3/2/16 at 1:30 PM of Client #3's file revealed "Assessment for ingesting and safe usage of personal care items" dated 3/17/15 indicated there was no history of ingesting such items and Client #3 could safely use all grooming items. Assessment outcome stated "No need for restrictive access to personal care products; supervision provided."</p> <p>Record review on 3/2/16 at 2:05 PM of Client #9's file revealed "Assessment for ingesting and safe usage of personal care items" dated 3/18/15 stated there was no history of ingesting such items and that Client #9 could safely use all grooming items. Assessment outcome stated "No need for restrictive access to personal care products; supervision provided."</p> <p>Record review on 3/2/16 at 2:50 PM of Client #14's file stated "Assessment for ingesting and safe usage of personal care items" dated 3/17/15 revealed there was no history of ingesting such items and that Client #14 could safely use all grooming items. Assessment outcome stated "No need for restrictive access to personal care</p>	{W 125}			

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{W 125}	<p>Continued From page 6 products; supervision provided. "</p> <p>Interview on 3/1/16 at 8:35 AM with Staff V verified she was told to ensure the cabinets were locked and she referred the surveyor to Staff P who concurred that all grooming supplies were to be locked in the grooming closets.</p> <p>Interview on 3/3/16 at 9:35 AM with Staff N, O and H confirmed they were told all grooming supplies were to be locked despite the assessments for Clients #3, #9 and #14 which indicated the Clients were safe around grooming supplies and there was no need for restricting access to their personal grooming items.</p> <p>3. Observation on 2/29/16 at 11:40 AM and 3/1/16 at 3:25 PM at Bigfoot Cottage revealed a locked cabinet in the laundry room which contained laundry supplies.</p> <p>Record review on 3/3/16 at 2:12 PM revealed no Clients living in the cottage had a signed Abridgment of Rights in their files pertaining to the locked laundry supplies.</p> <p>Interview on 3/3/16 at 3:25 PM with Staff I verified the laundry supplies were kept locked. Staff I stated she had been advised to do so with all chemicals and bleach. She verified keeping the cabinet locked prevented clients from having access to the laundry soap at their convenience to do their laundry. Staff I verified there were no Clients in the cottage that had a history of or were at risk of swallowing chemicals.</p> <p>4. Record review on 3/3/16 at 2:26 PM for Client #1</p>	{W 125}		

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{W 125}	Continued From page 7 revealed there was no signed consent for the use of psychoactive medications in her file.  Record review on 3/3/16 of Work Procedure LV 3.3 Psychoactive Medications Consent updated 2/24/16 revealed informed consent for the use of all psychoactive medications with Clients required a review and approval from the interdisciplinary team (IDT), the prescriber, the Human Rights Committee, the Client and/or their family/guardian or a designated decision maker.  An interview on 3/3/16 at 2:48 PM with Staff K verified the facility did not have the necessary consent for Client #1's psychoactive medications at the time it was requested by the survey team.	{W 125}			
{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 and interview the facility failed to ensure Clients who resided at 2 of 10 Cottages had access to telephones for private calls. This failure prevented Clients from having the opportunity for private telephone calls.  Findings include:  A. Observation on 3/4/16 at 10:16 AM at Sunrise	{W 135}			

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{W 135}	<p>Continued From page 8</p> <p>82/83 Cottage verified there were two corded telephones located in the kitchen areas on both sides of the cottage.</p> <p>Interview on 3/3/16 at 2:10 PM with Staff M verified Clients only had access to corded telephones in the kitchen areas of the cottage. She verified there was a corded telephone in the Attendant Counselor Manager 's (ACM) office but Clients and most staff don ' t have keys to get into the office.</p> <p>B. Observation on 3/2/16 from 2:15 PM to 3:18 PM at Hillside Cottage revealed Clients using the corded telephone in the office hallway area that connects the two kitchens.</p> <p>Interview on 3/3/16 at 9:40 AM with Staff C verified the identified corded telephone in the office hallway area is for incoming and outgoing Client(s) phone calls. Staff C confirmed there was not a private area for Clients to use the telephone when the ACM is off duty or away from the cottage.</p>	{W 135}		
{W 137}	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure appropriate clothing was provided for 1 of 13 Sample Clients (Client #8). This failure resulted in Client #8</p>	{W 137}		

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{W 137}	<p>Continued From page 9</p> <p>wearing clothing which was not the appropriate size, did not account for a variety of occasions, and placed the Client at risk of a loss of dignity.</p> <p>Findings include:</p> <p>Observation on 02/29/16 at 11:10 AM at Wildrose Cottage revealed Client #8 was wearing loose sweatpants without a belt or suspenders. Client #8 used his hands to hold up his pants as he walked.</p> <p>Observation on 03/01/16 at 9:50 AM at Wildrose Cottage revealed Client #8 wore sweatpants that were too big in the waist. Client #8 held them up as he walked. At 10:00 AM following his morning hygiene routine, Client #8 changed into another pair of sweatpants which were too big around the waist, forcing him to hold them up while walking. At 10:12 AM Client #8 walked with staff to the Adult Program (AP) building holding up his sweatpants. Observation at 10:19 AM revealed his shoes and socks were removed by an Adult Training Specialist (ATS) staff and his socks contained numerous holes. From 10:59 AM to 11:20 AM Client #8 was wearing a pair of sweatpants that were inside out. During this time, staff did not notice and there was no mention of Client #8's sweatpants being inside out. Later in the afternoon from 3:20 PM to 3:31 PM, Client #8 left the house and his shoes are not worn properly. Client #8 was walking with the heels of his shoes folded inside his shoes. Observation at 3:59 PM revealed Client #8 walked from the recliner to the bathroom with his buttocks showing and he attempted to hold his pants up as he walked. At 4:53 PM Client #8 walked to the Wrangle Inn holding his sweatpants up. Client #8 retrieved his adaptive equipment for dining and</p>	{W 137}			

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{W 137}	Continued From page 10 walked through the food line, holding up his pants. When he finished self-serving his meal, he used both hands to carry his dining tray, which resulted in his sweatpants falling down around his ankles. Staff and Clients were in the area.  Observation on 03/02/16 at 9:14 AM revealed Client #8 wearing sweatpants. He was standing near the maintenance area, holding onto his sweatpants to prevent them from falling down. Client #8 continued to hold his sweatpants up while he walked back to Wildrose Cottage with ATS staff.  Record Review on 03/02/16 of Client #8's Individual Habilitation Plan (IHP) dated 08/18/15 revealed Client #8 was working at maintaining dressing skills. Client #8 will "Use and/or purchase adaptive fasteners, put on clothing, as appropriate."	{W 137}			
{W 237}	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN  Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.  This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 13 Sample Clients (Client #8) had an objective with a data collection system that would allow someone to assess the Client's	{W 237}			

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{W 237}	Continued From page 11 progress. This failure resulted in an inability to measure the Client's progression or regression in the objective.  Findings include:  Record Review on 03/02/16 revealed Client #8's Individual Habilitation Plan (IHP) objective I.03 was "[Client #8's first name] will learn to follow high probability commands" at 80% after initial gesture. Examples of high probability commands are given: "tuck in your shirt", "Shake my hand", "Give me five", "Help me with this", and "put your clothes on".  The tracking sheet revealed only one data entry per shift. The tracking sheet did not explain, which high probability command was attempted. The tracking sheet did not allow for tracking the different commands given as examples in the training program. The tracking sheet did not allow for multiple opportunities to be given throughout the day.  Interview on 03/02/16 at 11:00 AM with Staff F, G and H verified the current way of collecting data did not allow them to know what Client #8 was actually doing. Staff G verified that a clearer data collection method would be needed to determine Client #8's progress or regression in this objective.	{W 237}			
{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	{W 249}			

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{W 249}	<p>Continued From page 12</p> <p>and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement Individual Habilitation Plans (IHP) for 2 of 13 Sample Clients (Client 's #8 and #12) and 1 of 11 Expanded Sample Clients (Client #14). Failure to implement IHP 's prevented Clients from gaining skills in identified needs, prevented them from increasing their independence and potentially delayed placement into a less restrictive environment.</p> <p>Findings include:</p> <p>A. Record review on 3/2/16 at 2:50 AM revealed Client #14 's IHP dated 11/10/15 contained formal training objectives: 1. D.16 " [Client #14 's first name] will touch her glass when she takes the last sip from her glass. " 2. D.04 " [Client #14 's first name] will use a napkin to wipe her face. " 3. H.04 " [Client #14 's first name] will touch the radio to indicate she wants to hear music. " Occupational Therapist assessment dated 1/22/16 stated Client #14 is right hand dominant and staff may assist in feeding. The Active Treatment Schedule stated staff are to work with Client #14 to get her to touch her utensils while dining, she is able to select her own clothing for the day, and she will take her dirty clothing to the hamper.</p> <p>Observation on 2/29/16 at 11:40 AM at Evergreen Cottage, revealed Client #14 being led into the</p>	{W 249}			

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{W 249}	<p>Continued From page 13</p> <p>dining room by Staff A. Staff A sat next to her, and spoon feed Client #14. Staff A lifted the glass to Client #14 's mouth for her when assisting her to drink. After the meal was finished, Staff A wiped Client #14 's mouth for her using a pre-moistened wash cloth from a small bowl that was sitting on the table. At no time during the meal did Staff A cue Client #14 to do anything for herself. Following the meal, Staff A led Client #14 into the living room and turned the radio on for her. Client #14 was not cued to touch the radio.</p> <p>Observation on 3/1/16 at 8:00 AM at Evergreen Cottage, revealed Client #14 sitting at the dining room table with Staff A sitting next to her. Staff A spoon fed Client #14. When asked if Client #14 was able to feed herself, Staff A replied Client #14 is tactile defensive, often yells at requests made of her and it takes a lot to get her to eat at the table. Following the meal, staff wiped Client #14 's mouth for her and led her into the living room to sit in a recliner. Staff asked Client #14 if she wanted to listen to music. Staff then proceeded to turn on the CD player.</p> <p>Interview on 3/3/16 at 9:35 AM with Staff H, N and O revealed the Active Treatment Schedule was not accurate and Client #14 does not engage in activities. They reported if staff request Client #14 to engage in any task, she yells loudly, disturbing her peers on the cottage, thus they make few demands of her in an effort to stop her from yelling. Staff H reported Client #14 's tracked maladaptive behavior of yelling showed significant decline in episodes of yelling the past year. Staff H, N and O verified staff should be implementing the current IHP objectives in an effort to help Client #14 gain independent living skills.</p>	{W 249}			

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{W 249}	<p>Continued From page 14</p> <p>B. Record review on 3/2/16 of Client #12 's IHP dated 6/11/15 revealed a Non Programming Service (NPS) Plan 01D, " [Client #12 's first name] will be provided knee pads to wear when walking with assistance to prevent injury to his knees from possible falls related to unsteadiness. " The Physician Orders dated 1/6/16 revealed " NPS 01D [Client #12 's first name] will be provided knee pads to wear when walking with assistance at the Adult Programs training area to prevent injury to knees from possible falls relating to unsteadiness. "</p> <p>Observation on 3/2/16 at 10:05 AM in AP room #7 revealed staff assisted Client #12 to walk to the bathroom. Staff J placed a soft-cap on his head and walked with him to the bathroom. Staff J did not check to see if he had knee pads on before walking with him while using a gait belt.</p> <p>Interview on 3/2/16 at 10:11 AM with Staff J verified Client #12 was not wearing knee pads when she assisted him to the bathroom.</p> <p>C. Record Review on 03/02/16 revealed that Client #8's IHP dated 8/18/2015 listed treatment program "N.14 [Client #8's first name] will remain on grass areas vs. road surfaces during personal leisure time spent behind the 74/75 building" and Client #8's Dietary instructions stated "Encourage sips of liquid throughout meal."</p> <p>Observation on 03/01/16 at 9:43 AM revealed Client #8 walked behind Cascade74/75 Cottage where maintenance staff were working. Client #8 walked in between two of the workers parked cars and in and out of the service road. At 10:41 AM Client #8 walked out the back door of the</p>	{W 249}		

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{W 249}	Continued From page 15 Adult Program (AP) building on the service road towards maintenance. At 5:04 PM Client #8 went to the Wrangle Inn to eat dinner. He ate all of his meal, then poured 3 glasses of juice, and drank each glass of juice in one continuous gulp. The staff did not encourage him to take sips.  Observation on 03/02/2016 at 10:05 AM Client #8 got up and headed down the hallway of AP and walked out the back door towards maintenance. At 10:08 AM Client #8 and Staff U were walking down the middle of the service road.  Interview on 03/03/16 at 9:00 AM with Staff F, G and H verified Client #8 is a very difficult Client to work with and he had been left alone by staff for many years to prevent behavioral outbursts. Staff G verified Client #8's objective to remain on grass areas vs road surfaces needed to be implemented by all staff when working with him. Staff F, G and H verified Staff should be encouraging Client #8 to sip his liquids.	{W 249}			
{W 312}	483.450(e)(2) DRUG USAGE  Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to prevent staff from writing plans for the use of emergency chemical restraints for 2 of 13 Sample Clients (Client #2 and #5) and 9 of 11 Expanded Sample Clients (Clients #16 - #24).	{W 312}			

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{W 312}	<p>Continued From page 16</p> <p>This failure resulted in medications being listed and planned as an emergency treatment measure in the Clients' Positive Behavior Support Plans (PBSP).</p> <p>Findings include:</p> <p>Client #5: Record review on 03/02/16 at 1:30 PM of Client #5's PBSP dated 10/16/15 revealed a "STAT" psychoactive medication [REDACTED] as Step 5 in managing Client #5's aggression, self-injurious behavior (SIB) or destructive behaviors. The facility provided a corresponding physician's order for Client #5's psychoactive medication [REDACTED] 2mg, to be used as a "STAT" medication.</p> <p>Interview on 03/03/16 at 9:00 AM with Staff W, X and Y verified that Client #5 had a step in his PBSP for the administration of medication when certain behavioral criteria were met. Staff Y stated he was aware other Clients on campus had "STAT" medication consents and instructions in their PBSPs. Staff Y verified that "STAT" medication referred to preplanned medications for those Clients who display specific behaviors listed in their PBSPs. Staff Y stated these plans were in accordance with Lakeland Village's emergency restraints policy.</p> <p>After it was determined other Clients had "STAT" medication as well, copies of every other Clients' "STAT" medication consents were requested. Consents were produced for Client #2 and Client #16 - 24.</p> <p>Interview on 03/03/2016 at 12:30 PM with Staff EE verified the facility had sent "STAT" medication orders through the Interdisciplinary</p>	{W 312}		

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{W 312}	<p>Continued From page 17</p> <p>team, Human Rights Commission, Psychologist, Pharmacist and the Physician before obtaining consent from the Client's guardians.</p> <p>Client #2: Record review on 3/3/16 at approximately 2:30 PM of Client #2's PBSP dated of 8/17/15 revealed a "STAT" psychoactive medication [REDACTED] was Step 4 in managing Client #2's aggression. The record review also revealed that a "STAT" could be used was Step 4 in managing his unsupported departures (medication not identified) and was Step 4 in managing his agitation [REDACTED]. The facility provided a corresponding physician's order for Client #2 for the psychoactive medications, [REDACTED] 2mg and [REDACTED] 50mg to be used as "STAT" medications.</p> <p>Client #16: Record review on 3/3/16 at approximately 2:30 PM of Client #16's PBSP dated 10/27/15 revealed a "STAT" psychoactive medication (not identified) was Step 4 in managing Client #16's disruptive behavior. The facility provided a corresponding physician's order for Client #16 for the psychoactive medication [REDACTED] 2mg to be used as "STAT" medication.</p> <p>Client #17: Record review on 3/3/16 at approximately 2:30 PM of Client #17's PBSP dated 4/21/15 revealed a "STAT" psychoactive medication [REDACTED] was Step 4 in managing Client #2's aggression. The record review revealed a "STAT" medication, [REDACTED] could be used was Step 4 in managing his SIB, was Step 4 in managing his Property Destruction and was Step 4 in managing his verbal aggression. The facility provided a</p>	{W 312}		

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{W 312}	<p>Continued From page 18</p> <p>corresponding physician's order for Client #17 for the psychoactive medications [REDACTED] 5mg [REDACTED] to be used as "STAT" medication for managing Client #17's behaviors.</p> <p>Client #18: Record review on 3/3/16 at approximately 2:30 PM of Client #18's PBSP dated 1/26/16 revealed a "STAT" psychoactive medication [REDACTED] was Step 4 in managing Client #18's aggression and his agitation. The facility provided a corresponding physician's order for Client #18 for the psychoactive medication [REDACTED] 5mg to be used as "STAT" medication for managing Client #18's behaviors.</p> <p>Client #19: Record review on 3/3/16 at approximately 2:30 PM of Client #19's PBSP dated 9/30/15 revealed a "STAT" psychoactive medication [REDACTED] ) was Step 4 in managing Client #19's aggression. The record review also revealed that a "STAT" medication [REDACTED] could be used as Step 2 in managing Client 19's property destruction. The facility provided a corresponding physician's order for Client #19 for the psychoactive medication [REDACTED] 2mg to be used as "STAT" medication for managing Client #19's behaviors.</p> <p>Client #20: Record review on 3/3/16 at approximately 2:30 PM of Client #20's PBSP dated 10/2/15 revealed a "STAT" psychoactive medication [REDACTED] was Step 4 and [REDACTED] was Step 5 to manage Client #20's aggression. The record review revealed a</p>	{W 312}		

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{W 312}	<p>Continued From page 19</p> <p>" STAT " medication [REDACTED] could be used as Step 4 in managing Client 20 ' s screaming. The facility provided a corresponding physician ' s order for Client #20 for the psychoactive medication [REDACTED] 5mg was Step 4 and [REDACTED] 2mg was Step 5 to be used as " STAT " medications for managing Client #20 ' s behaviors.</p> <p>Client #21: Record review on 3/3/16 at approximately 2:30 PM of Client #21 ' s PBSP dated 3/25/15 revealed a " STAT " psychoactive medication ([REDACTED]) was Step 4 and [REDACTED] was Step 5 to manage Client #21 ' s aggression and SIB. The facility provided a corresponding physician ' s order for Client #21 for the psychoactive medications [REDACTED] 2mg and [REDACTED] as " STAT " medications for managing Client #21 ' s behaviors.</p> <p>Client #22: Record review on 3/3/16 at approximately 2:30 PM of Client #22 ' s PBSP dated 5/28/15 revealed a " STAT " psychoactive medication (not identified) was Step 3 to manage Client #22 ' s aggression. The record review revealed psychoactive medication (not identified) was Step 4 in managing Client # 22 ' s SIB and Step 3 in managing Client #22 ' s property destruction. The facility provided a corresponding physician ' s order for Client #22 for a psychoactive medication [REDACTED] 2mg as a " STAT " medication for managing Client #22 ' s behaviors.</p> <p>Client #23: Record review on 3/3/16 at 2:12 PM of Client #23</p>	{W 312}		

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{W 312}	<p>Continued From page 20</p> <p>'s PBSP dated 10/23/15 and corresponding physician's order provided by the facility revealed "STAT" medications [redacted] e 50mg, and if no relief after 2 doses, then [redacted] 2mg) to be administered was Step 4 in managing Client #23's aggression, Step 4 in managing SIB, and was Step 3 in managing disruptive behaviors defined as "loud vocalizations" which continue for 15 minutes.</p> <p>Client #24 Record review on 3/3/16 for Client #24 revealed a "STAT" Medication Criteria Summary was a part of his PBSP and Medical "STAT" Guideline for [redacted] 2 mg was Step 4 to respond to and manage Client #24's challenging behavior. The facility provided a corresponding physicians order for Client #24 for a psychoactive medication [redacted] 2 mg as a "STAT" medication for managing Client #24's behaviors.</p>	{W 312}		
{W 440}	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all Clients participated in evacuation drills quarterly on each shift. This failure resulted in the facility not knowing who participated in evacuation drills and put all Clients and staff at risk of not evacuating quickly and safely during an emergency.</p> <p>Findings include:</p> <p>Record review on 3/3/16 of all Fire Alarm Reports</p>	{W 440}		

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{W 440}	Continued From page 21 held in 2015 and 2016 revealed clients were not listed on any Fire Alarm Report and staff were inconsistently listed on Fire Alarm Reports.  Interview on 3/3/16 at 3:08 PM with Staff D revealed she didn't know, based on the report, which Clients were evacuated.  Interview on 3/3/16 at 4:00 PM with Staff E revealed Client's names were not listed on the form, and she was unsure of who had evacuated during any drill. Staff F confirmed the Fire Alarm Report is the only documentation where this information could be found.	{W 440}			
{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: Based on interview and record review, the facility failed to ensure all Clients actually evacuated during at least one drill each year, on each shift. This failure resulted in Clients and staff not rehearsing for emergencies and put all Clients and staff at risk of not evacuating quickly and safely during an emergency.  Findings include:  Record review on 3/3/16 of all Fire Alarm Reports held in 2015 and 2016 revealed the following:  1. Clients were not listed on any Fire Alarm Report. 2. Staff were inconsistently listed on Fire Alarm Reports.	{W 445}			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 445}	Continued From page 22 3. The following cottages did not conduct a full evacuation drill during the night shift in 2015 and 2016 to date: Cascade, Willow, Wildrose, Bigfoot, Apple, Evergreen, Pinewood, Hillside, and Sunrise 84/85.  Interview on 3/3/16 at 3:08 PM with Staff D revealed she did not know, based on the report, which Clients were evacuated. After reviewing the Fire Alarm Reports, Staff D verified the full evacuation drills did not occur as required and thought staff were not filling out paperwork correctly due to the inconsistencies discovered on the forms.  Interview on 3/3/16 at 4:00 PM with Staff E revealed a plan of correction would be developed if an issue arose during a drill. Staff E confirmed that the Fire Alarm Report is the only documentation where this information could be found.	{W 445}			
{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, the facility failed to investigate problems with evacuation drills. This failure prevented the facility from ensuring fire drills went smoothly and problems did not continue unresolved.  Findings include:  Record review on 3/3/16 revealed the following inconsistencies in documentation or unusual	{W 448}			

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{W 448}	Continued From page 23 incidents. None of the below Fire Alarm Reports were investigated as evidenced in the lack of any plans of correction or attached documentation.  1. Fire Alarm Report 2/23/15 for Apple Cottage at 3:45 AM revealed a false alarm due to the oven "smoking while staff cooking on 92 side." This is a time of day when clients are typically sleeping. 2. Fire Alarm Report 3/3/15 for Pinewood Cottage at 1:47 AM revealed "False Alarm" was checked, the drill section was completed, and the false alarm and switchboard operation sections of the form were blank. This drill was not signed by the Safety Officer or designee. 3. Fire Alarm Report 3/25/15 for Apple Cottage at 12:59 AM revealed "No" was checked for "During the drill was #3333 used to call front desk?" 4. Fire Alarm Report 3/25/15 for Hillside Cottage at 2:36 AM revealed this to be a simulated drill. "No" was checked for "Were doors and windows closed? (simulated fire area)" and "Yes" was checked for "Were windows and doors closed for the fire area?" 5. Fire Alarm Report 3/26/15 for Wildrose Cottage at 4:55 AM revealed "No" was checked for "Do doors latch when closed (per State Fire Marshall?)" 6. Fire Alarm Report 6/9/15 for Bigfoot Cottage at 12:53 AM revealed the main alarm panel was reset and an evacuation route was written on the form. "No" was checked in the box for "Were all clients and staff evacuated?" 7. Fire Alarm Report 6/17/15 for Hillside Cottage at 1:55 AM revealed this to be a simulated drill. "No" was checked for "Were doors and windows closed? (simulated fire area)" and "Yes" was checked for "Were windows and	{W 448}			

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{W 448}	<p>Continued From page 24</p> <p>doors closed for the fire area? "</p> <p>8. Fire Alarm Report for 8/6/15 for Hillside Cottage at 1:50 AM revealed a false alarm due to a smoking pan on the stove. This is a time of day when clients are typically sleeping.</p> <p>9. Fire Alarm Report 8/28/15 for Wildrose Cottage at 3:30 AM revealed " No " was checked for " Was front desk notified of time and place prior to drill by dialing " 0 " ? "</p> <p>10. Fire Alarm Report 9/1/15 for Hillside Cottage at 12:55 AM revealed " No " was checked for " Were employees calm and correct in response? " and " No " was checked for " Do doors latch when closed (per State Fire Marshall?). "</p> <p>11. Fire Alarm Report 9/9/15 for Wildrose Cottage at 1:32 AM revealed " No " was checked for " Was front desk notified of time and place prior to drill by dialing " 0 " ? "</p> <p>12. Fire Alarm Report 12/1/15 for Evergreen Cottage at 11:10 pm revealed " Yes " and " No " were checked for " Any procedural, mechanical, or operational problems? "</p> <p>13. Fire Alarm Report 12/10/15 for 82/83 Sunrise Cottage at 1:40 AM revealed " No " was checked for " During the drill was #3333 used to call the front desk?, " " No " was checked for " Was a silent drill conducted between 9:00 PM - 6:00 AM, " " No " was checked for " Were employees calm and correct in response?, " " Yes " was checked for " Were clients and staff evacuated?, " and " No " was checked for " Was main alarm panel reset? "</p> <p>Interview on 3/3/16 at 3:08 PM with Staff D verified if a staff was documented as not being calm during the drill, she would send the form back to the supervisor for comments. After reviewing the Fire Alarm Reports, Staff D stated</p>	{W 448}			

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{W 448}	Continued From page 25 she thought staff were not filling out paperwork correctly due to inconsistencies on the forms.  Interview on 3/3/16 at 4:00 PM with Staff E verified a plan of correction would be developed if an issue arose during a drill.	{W 448}			