

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2013
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NAME OF PROVIDER OR SUPPLIER CHELSEA GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 26511 NE VIRGINIA ST, PO BOX 1394 DUVALL, WA 98019
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W 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an Annual Recertification conducted at Chelsea Group Home on 11/17/13 to 11/19/13. A sample of 3 residents was selected from a census of 5 residents in the facility. The Expanded Sample included 2 current residents.</p> <p>The survey was conducted by: Janette Buchanan, R.N., B.S.N. Claudia Baetge M.A.</p> <p>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</p> <p>Telephone: (360) 725-2405 Fax: (360) 725-2642</p>	W 000		
W 108	<p>483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS</p> <p>The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to comply with State</p>	W 108	<p>W 108</p> <ol style="list-style-type: none"> The facility's maintenance supervisor will replace the outdoor light near the facility entrance by 1/8/14. The carpeting in the living room and common areas was cleaned on 12/16/13. The doorknob on the door leading to the stairwell was loose and not securely fastened was repaired by the maintenance supervisor on 11/19/13. The maintenance supervisor will sand and paint the plywood that is on the base of the stairwell and landing area by 1/15/14. The plywood panels that are nailed to the wall in Resident #2's bedroom were removed, the holes in the sheetrock were repaired on 12/26/13, and the bedroom will be painted by the maintenance supervisor by 1/31/14. The facility's maintenance supervisor will repair the damaged ceiling in Resident #5's bathroom and remove any possible mold by 1/17/14. <p>In future the facility manager and QIDP will comply with state regulations related to providing a well repaired and maintained environment which is free from safety hazards by doing a monthly walk through of the facility starting January 2014.</p> <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">DEC 31 2013</p> <p style="text-align: center;">DSHS/ADSA/RCS/BAAU</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 12/27/13
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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 Regulation (WAC 388-78A-3090) with regards to ensuring a hazard free and well maintained environment for 2 of 3 sampled residents (Resident #1 & #2) and 1 of 2 expanded sample residents (Resident #5). This failure placed residents at risk for harm and diminished quality of life. Findings include: WAC 388-78A-3090 requires the facility provide a safe, sanitary and well maintained environment for residents. Refer to attached Statement of Deficiencies dated 11/19/13, for details of failed practice under WAC 388-78A-3090.	W 108		
W 113	483.410(c)(3) CLIENT RECORDS The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update time limited consents. This failure violated 1 of 3 sampled residents (Resident #1) rights to confidentiality with information being released without individual/guardian consent and denied resident/guardian the opportunity to make informed decisions about restrictive practices. Findings include: Record review revealed that Authorization to Release or Exchange Information consent with Lakeshore Clinic expired on 10/4/13. Professional Plan of Care revealed Resident #1 was seen at Lakeshore Clinic on 10/28/13.	W 113	W 113 Resident #1's consents: Release of information for Lakeshore and other providers that Resident #1 is seen by, General consents, Bill of Rights, Resident Rights/Boarding Homes, Active Treatment Refusal, Activity Authorization, Personal Items Consent, Long Distance Telephone Consent, Financial Authorization, Individual/Guardian Grievance, Protection of Rights, and Psychotropic medications consents were signed by the guardian on 11/17/2013 and mailed back to the facility on 12/10/13. Going forward the QIDP will have all consents ready for the guardian to sign at each Resident's IPP. If the guardian does not attend the IPP, the facility manager will mail the consents to the guardian within that week.	

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W 113	Continued From page 2 Record review revealed the Release of Information - authorizing facility to release records pertaining to medical, educational, social, and psychological issues to professional persons and agencies expired on 07/18/13. Record review of Professional Care Plans which documented Resident #1 's medical visits revealed resident was seen by medical providers on: 11/05/13, 10/22/13, 10/17/13, 10/16/13, 10/11/13, 9/25/13, 9/23/13, and 9/11/13. Record review revealed the following consents expired on 07/18/13: General Consent, Bill of Rights, Resident ' s Right/Boarding Homes, Procedure Guidelines for Individuals Who Refuse to Participate in Active Treatment, Activity Authorization, Personal Items Consent, Long Distance Telephone Consent, Financial Authorization and Individual/Guardian Grievance Procedure. Protection of Individual ' s Rights; expired 10/04/13. Record review of Physicians Order ' s dated May 2013 through August 2013 revealed Resident #1 is prescribed [REDACTED] 3 20 mg tablet a day and [REDACTED] 3 1mg tablet PRN for agitation. Consent for the use of these Behavior Control Medications expired on 07/18/13 and were last approved by the guardian on 06/18/12. Interview with Staff B acknowledged individual/guardian consents had expired, had not been updated and were to be renewed annually.	W 113	W 159 The QIDP will review and update Resident #1's CFA by 1/31/14. The QIDP will contact Camelot Society's consulting behavior analyst to update Resident #1's PBSP by 1/31/14. Going forward the QIDP will update all residents CFA by 30 days after last IPP and the behavior analyst will update PBSP's by 30 days following IPP's. The QIDP will review Resident #1's Meal Prep program and clarify steps/tasks to find out what step Resident #1 is on and revise program accordingly by 1/31/14. Resident #1 has refused to participate in meal prep over the last few months and has had an increase in behaviors which could be causing the refusals. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. The QIDP will remove the step #4: "A bowl of fruit will be kept out and available..." by 1/31/14 because it is no longer relevant to the decrease stealing objective. Staff is not required to write a GER for instances of stealing unless it is something that another resident did not get returned or was ruined. The two occasions that the previous QIDP noted were found on Resident #1's behavior tracking sheet and were instances involving staff which we do not write GER's for either.		
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.	W 159	W 159 The QIDP reviewed data for Resident #2's tooth brushing objective on 7/2013 during his last IPP. Since we review objectives semi-annually, the QIDP will review Resident #2's objectives by 1/31/14 and update them accordingly at that time.		

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W 159	Continued From page 3 This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (Resident #1, #2, & #3) and 2 of 2 expanded sample residents (Resident #4 & #5) continuous active treatment programs were monitored, coordinated, updated and integrated as required. This failure caused residents' progress to go unrecognized, placed residents at risk for diminished ability of skill development/independence. Findings Include: All record reviews and interviews were conducted between 11/17/13 and 11/19/13 unless otherwise specified. Analysis of active treatment program: Resident #1: Record review of Resident #1 's Comprehensive Functional Assessment (CFA) and Positive Behavior Support Plan (PBSP) had not been completed for 2013. CFA and PBSP were last completed on 06/12/2012. Staff B acknowledged Resident #1 's CFA and PBSP had not been completed. Record review of Resident #1 's Individual Program Plan (IPP), dated 06/11/13 revealed objective: Will assist in the kitchen with meal prep and cooking on Monday. The plan to meet this objective included the following steps: 1) Staff will provide Resident #1 with assistance in making choices, portion control and food preparation tasks, as needed. 2) Staff to document resident success on the achievement sheet located in the program book. Data to be collected on Mondays. 3) Encourage resident to help prepare dinner at least one time per week on Mondays. Dinner preparation to include; such tasks as assisting	W 159	Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. The QIDP will remove Resident #2's objective to obtain a low calorie snack by 1/31/14 since Resident #2 has already met his goal. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. Resident #2 had an annual IPP 7/2013 where all objectives were reviewed and updated. Since we review semi-annually, Resident #2 is not due to have objectives reviewed until 1/2014. An admit IPP was done and no changes were made and all consents were appropriate with the exception of locking the extra food storage vs locking the kitchen. Verbal consent was given by the guardian to lock the kitchen. The QIDP will review Resident #2's objectives by 1/31/14 and make any necessary changes or updates at that time. The QIDP will update Resident #2's CFA by changing the name of the facility to Chelsea Group Home by 1/31/14 but everything else is still current and appropriate. Camelot Society's consulting behavior analyst is updating Resident #2's PBSP and will have that in place by 1/31/14. Going forward the QIDP will review and update, if necessary, all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings.		

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W 159	Continued From page 4 with food preparation, setting the table and helping to clear the table. 4) Staff are to encourage resident to wash her hands prior to assisting and as often as necessary during the tasks. 5) Encourage resident to engage in these tasks when she is at home for breakfast and lunch, as she is willing. 6) Encourage resident to rinse her dishes and put them in the dishwasher after meals. 7) Staff to encourage resident to be as independent as possible in performing these tasks. Record review of the QIDP (Qualified Intellectual Disabilities Professional) reviews revealed " Meal Prep and Cooking " program for Resident #1 captured the level of participation and quantified the results: 1st quarter (June-4/4 opportunities, July-5/5 opportunities, August-4/4 opportunities. 2nd Quarter (Sept - 4/5 opportunities, Oct 1/4 opportunities). There was no documentation to indicate what tasks of " Meal Prep and Cooking " Resident #1 had completed. Record review of Achievement Sheet dated October 2013 revealed staff document " N " if no opportunity, " 0 " if resident refused. Data revealed for " Assists in kitchen Monday " program: Resident refused 10/7/13, 10/21/13, 10/28/13 and no opportunity was recorded for 10/14/13. Meal Prep and Cooking data for Resident #1 was not monitored by QIDP to address why Resident #1 was not participating. Record review of Resident #1 ' s Individual Program Plan, dated 06/11/13 revealed objective: Resident will decrease the number of times she steals from others to 2 times a year or fewer by 06/12/14. The plan to meet this objective included the following steps: 1) Staff to follow procedures per Positive	W 159	The QIDP will review data for Resident #3's PT objective by 1/31/14. Resident #3 was assessed by Camelot Society's consulting PT on 12/9/13 and no changes were made. Going forward Resident #3 will be assessed by the PT annually during their IPP time and the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. The QIDP will revise all the objectives for Resident #4 by 1/31/14. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. The QIDP will update Resident #5's CFA and IPP by 1/31/14. Going forward the QIDP will update all residents CFA and IPP by 30 days after last IPP. The QIDP will have Camelot Society's behavior analyst adjust Resident #5's PBSP to include elopement in the historical data section since it has not occurred in the past 14 months it will be removed from the active plan. The alarm will remain for safety purposes. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings.		

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W 159	<p>Continued From page 5</p> <p>Behavior Support Plan, which is located in program book under the " PBSP " tab.</p> <p>2) Staff to document incidents on Positive Behavior Support Plan Data Sheets located in program book.</p> <p>3) Document incidents in T-noted and in GERS.</p> <p>4) A bowl of fruit will be kept out and available for resident to snack on should she become hungry between meals. Fresh vegetables will also be available in the refrigerator.</p> <p>5) Resident will replace any items that she may steal and consume or destroy. Help her to understand that when she takes all the ice cream, no-one else gets to have any and therefore she needs to replace it for them.</p> <p>6) PBSP to be updated annually and reviewed by Human Rights Committee.</p> <p>Record review of facility General Events Report (GER) from 05/15/13 to 11/16/13 revealed there were no GER ' s completed to reflect incidents of stealing on 07/17/13 and 08/02/13 as recorded in OIDP quarterly summary (June, July, and August, 2013) for Resident #1.</p> <p>Interview with Staff A & B acknowledged they could not explain how Step 4 ("A bowl of fruit will be kept out and available for resident to snack on should she become hungry between meals. Fresh vegetables will also be available in the refrigerator ") was relevant to Resident #1 ' s IPP objective of decreasing stealing.</p> <p>Resident #2:</p> <p>Record review of Resident #2 ' s Individual Program Plan (IPP), dated 07/10/13 revealed objective: Will brush his teeth with assistance 3 times daily at least 27 days of the month for 6 consecutive months by 07/10/14. The plan to meet this objective included the following steps:</p> <p>1) Staff to remind Resident #2 to brush his teeth three times a day after meals. Remind him to</p>	W 159			

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W 159	Continued From page 6 brush at other times if food particles are on his teeth. Attempt to use Sonicare again and see if he will tolerate this and use it properly. 2) Dental exams/cleanings every 4 months from dental hygienist. Resident is currently seen at U of W DECOD. 3) Provide compliments to resident on having a nice smile and healthy looking teeth after he brushes. Remind him on occasion of the importance of caring for his teeth so he will have them his whole life. 4) Encourage him to brush well (all surfaces of his teeth - especially the front) twice daily for 2 minutes. Utilize an " hourglass " timer if this is helpful. Staff is to physically assist him in brushing areas that he may miss to ensure all of his teeth get brushed well. Concentrate on the gum line. 5) Resident has a fluoride dental cream to be used twice daily. Record review of the Qualified Intellectual Disabilities Professional (QIDP) Quarterly Summary revealed data review and analysis had not been completed for 1st Quarter (July, August, September 2013), 2nd Quarter (October , November, December 2012), 3rd Quarter (January, February, March 2013) and 4th Quarter (April, May, June 2013). Record review of Resident #2 ' s IPP, dated 07/10/13 revealed objective: Will independently obtain a low-calorie snack for his lunch on 5 out of 5 consecutive trials by 07/14/13. However, record review revealed Resident #2 has met this objective on 10/13/11. The plan to meet this objective included the following steps: 1) Staff to follow program TA located in program book and document on achievement sheet and on program data sheet. 2) Staff to take data on this skill 3 times weekly.	W 159			

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W 159	<p>Continued From page 7</p> <p>3) Staff are to encourage resident to obtain a healthy snack every time he makes his lunch and at other items when he so deserves.</p> <p>4) Staff may need to assist resident in choosing a healthy option and with portion control.</p> <p>Record review of the QIDP Quarterly Summary revealed data review and analysis had not been completed during the past four quarters. Staff were documenting that Resident #2 obtained a low calorie snack, however cueing level was documented with a check mark instead of type of cueing the resident required: verbal, prompt, independent, etc. There was no evidence that collected data for Resident #2 had been systematically analyzed and used to make changes in the programs. Data was being documented by staff in the program book, however programs had not been modified or changed in response to Resident #2 's specific accomplishments, need for new programs, or difficulties in acquiring or maintaining skills. Data had not been analyzed to determine if the data collection was complete and accurate.</p> <p>Resident #2 's IPP (Individual Program Plan), CFA (Comprehensive Functional Assessment) and PBSP (Positive Behavioral Support Plan) did not reflect that Resident #2 had a moved from one facility to another. Without the current assessments for Resident #2 staff would not know how to assist resident with his training, functional, and behavioral needs.</p> <p>Staff B acknowledged she had not completed the data review nor analyzed data for Resident #2 during the past year.</p> <p>Resident #3: Record review of Resident #3 's Individual Program Plan, dated 07/10/13 revealed objective: Will complete her physical therapy exercises 4</p>	W 159			

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W 159	Continued From page 8 times per week for 12 consecutive months by 09/10/14. The plan to meet this objective included the following steps: 1) See physical therapy program for procedures filed under program tab in chart and in program book. 2) Staff will obtain data 4 times weekly on Sunday, Monday, Tuesday, and Friday and record on data sheet found in program book under program tab. 3) Staff will also document on the achievement sheet that resident 's physical therapy exercises were completed on the scheduled days. 4) QIDP to monitor biannually or as needed. 5) Physical Therapist to monitor as needed. There was no evidence data for Resident #4 had been systematically analyzed and used to make changes in the programs. Data was being documented by staff, however programs had not been modified or changed in response to Resident #4 's specific accomplishments, need for new programs, or difficulties in acquiring or maintaining skills. Data had not been analyzed to determine if the data was complete and accurate. Resident #4: Record review of Resident #4 's Individual Program Plan, dated 11/12/12 revealed objective: Will floss her teeth with dental sword independently twice per week according to task analysis on 3 of 3 trials for 3 consecutive opportunities by 11/20/13. (Tuesdays and Thursdays). The plan to meet this objective included the following steps: 1) See 8000 Dental objective below. (Objective found on CFA and revealed: Strengths: Oral Care: Resident brushes her own teeth. She uses a Sonicare tooth brush with staff assistance. Condition of Teeth/Gums: Oral hygiene is good. Last dental exam on 06/25/12 indicated general	W 159			

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W 159	Continued From page 9 condition of teeth is good. Sonicare toothbrush. Concerns: Oral Care: Needs improvement. Resident needs to work on oral hygiene. Recommended brushing 2xday for 2 minutes, and flossing at least once a day and use Condition of Teeth/Gums: Slightly red and inflamed. Program in place to teach and encourage resident to floss regularly to improve gum health. 2) ISC to take data twice per week when resident participates in the program. 3) QIDP to track quarterly or as needed. Record review of Resident #4 's Individual Program Plan, dated 11/12/12 revealed the QIDP Quarterly Summary data review and analysis had been completed. However, IPP dated 11/20/12 revealed 1st Quarter (November 2012 - on step 4. Had 8 out of 9 opportunities (89% participation), December 2012 - on step 4. Had 10 out of 10 opportunities (100% participation), January 2013 - on step 4. Had 10 out of 10 opportunities (100% participation). One hundred percent participation was documented for Resident #4 for the second, third and fourth quarter in this area with verbal cueing although the objective revealed that resident was to be independent in this area. Staff B acknowledged that the previous QIDP had not analyzed data for Resident #4 correctly for the last year. Resident #5: Record review of Resident #5 's Comprehensive Functional Assessment (CFA) and Individual Program Plan (IPP) had not been completed for 2013. IPP was last completed on 07/26/12. Staff B acknowledged Resident #5 's CFA and IPP had not been completed. Record Review of Resident #5 's Positive Behavior Support Plan (PBSP) dated 08/22/13 revealed presenting behaviors: A) Assault; B)	W 159			

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W 159	Continued From page 10 Self-Injurious Behaviors; C) Elopement. However, IPP dated 07/26/12 revealed Resident #5 had no incidents of assault: 1st quarter (July, Aug, Sept. 2012), 2nd quarter (October, November, December 2012), 3rd quarter (Jan, Feb, March 2013) and 4th quarter (April, May, June 2013). " Elopement " was identified as a presenting behavior in PBSP revised 08/13/12 and 08/22/13. However, IPP dated 07/26/12 did not address this concern in regards to Resident #5 ' s Active Treatment Program. Interview with Staff D revealed Resident #5 has history of elopement and a window alarm that alerts staff if the window is opened. Staff D acknowledged Resident # 5 had not eloped in the last 14 months. Interview with Staff A, B and H acknowledged concerns with Active Treatment Programs in regards to overall monitoring and programming. QIDP failed to ensure any discrepancies/conflicts in Active Treatment Programs were resolved.	W 159	W 210 Resident #2 had an annual IPP 7/2013 where all objectives were reviewed and updated. Since we review semi-annually, Resident #2 is not due to have objectives reviewed until 1/2014. An admit IPP was done and no changes were made and all consents were appropriate with the exception of locking the extra food storage vs locking the kitchen. Verbal consent was given by the guardian to lock the kitchen. The QIDP will review Resident #2's objectives by 1/31/14 and make any necessary changes or updates at that time. The QIDP will update Resident #2's CFA by changing the name of the facility to Chelsea Group Home by 1/31/14 but everything else is still current and appropriate. Camelot Society's consulting behavior analyst is updating Resident #2's PBSP and will have that in place by 1/31/14. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings.		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility failed to have the IDT (Interdisciplinary Team) perform accurate assessments to supplement the preliminary evaluation (assessments) prior to admission, within 30 days of admission for 1 of 3 sampled residents (Resident #2). This failure did	W 210	W 227 QIDP will update Resident #2's IPP to state Chelsea Group Home by 1/31/14. Resident #2's personal care objective to shower thoroughly is an informal program so no documentation is required. The staff is referred to use the formal showering program for procedures to follow so they know how to assist Resident #2 with showering. This objective will be removed from programs by 1/31/14. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings.		

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W 210	Continued From page 11 not ensure Resident #2 had an accurate assessment that was current, relevant and valid for an IPP (Individual Program Plans) or CFA (Comprehensive Functional Assessment) to be developed after the 09/06/13 admission. Findings include: All interviews and record reviews were conducted 11/17/13 through 11/19/13 unless otherwise specified. Review of Resident #2 's records revealed all documentation reflected Resident #2 continued to live at Barclay Group Home. Resident #2 was admitted to Chelsea Group Home on 1 13. Resident #2 's IPP, CFA (Comprehensive Functional Assessment) and Behavioral Support Plan all reflected that Resident #2 was at Barclay Group Home which did not give the staff at Chelsea Group Home an accurate accounting of Resident #2 's current needs in order to know how to care for resident. Interview with Staff B revealed that the IDT (Interdisciplinary Team) met on 09/26/13 to discuss Resident #2 's admission; however no documentation, evaluations or assessments were completed at that time that would assist staff in caring for Resident #2.	W 210	Resident #2 did not shave on 11/18/13 because it is his choice to shave and he did not want to that morning. Staff encouraged him but he refused. After talking with staff it was brought up that he did shave later that evening. Going forward staff will encourage Resident #2 to shave daily but it is ultimately the choice of Resident #2. During the next staff meeting on 1/14/14 the facility manager will have an in-service on monitoring residents during snack and meal time. Going forward staff will sit with residents at the table during snack and meal time to encourage Resident #2 to slow down when eating to prevent choking and ensure all residents are being monitored for choking. The QIDP will revise Resident #2's laundry program to state that the laundry hamper will be stored in the laundry room. Resident #2 does not want his laundry basket stored in his room and will move it to the laundry room each time it is placed in the bedroom. A semi-annual review of the data for this program will be reviewed by 1/31/14. The facility manager will include Resident #2's name on the house laundry list day for Mondays and the list will be gone over at the next team meeting on 1/14/14. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings. The QIDP will remove Resident #2's objective to obtain a low calorie snack by 1/31/14 since Resident #2 has already met his goal. Going forward the QIDP will review and update if necessary all resident objectives semi-annually and review them with staff after the CFA and objectives have been updated for the year at staff meetings.		
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, interviews and record reviews, the facility failed to ensure that 1 of 3	W 227			

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W 227	<p>Continued From page 12</p> <p>sampled residents (Resident #2) had an IPP (Individual Program Plans) that was accurate and current. This failure denied Resident #2 accurate training objectives.</p> <p>Findings include:</p> <p>All observations, interviews and record reviews were conducted 11/17/13 through 11/19/13 unless otherwise specified.</p> <p>Record review revealed that Resident #2's IPP Objective List was not current for the facility that resident currently resided at. The IPP Objective List stated that Resident #2 was appropriately placed a Barclay ICF-IID Facility. Resident #2 currently resides at Chelsea Group Home as 11/13.</p> <p>Resident #2 had personal care objectives in the following areas that were not followed:</p> <ol style="list-style-type: none"> 1. Shower thoroughly: First noted in 06/96 and stated that it started 07/10/13, although was not a formal program according to the tracking schedule. In the program plan it stated that staff were to see formal showering program for procedures to follow under the training tab in the program book. The plan goes on further to state that Resident #2 was unable to develop independence in the skills of bathing in 5 years of formal programming. No documentation was available on how resident was doing with showers. <ul style="list-style-type: none"> a. On 11/18/13 Resident #2 did not appear to have shaved. 2. He needs to eat a slower pace: First noted 11/01 and started 07/10/13 with tracking only being done as needed. The plan stated that Resident #2 had a formal program to learn to eat more slowly for over 3 years without success and did not appear he would learn to do so. Staff were to sit with him during meals to encourage him to slow down. Staff were documenting they were 	W 227	<p>The facility manager will go over how and when to document liquid intake for Resident #2 at the next staff meeting on 1/14/14. The staff is trained to document each time 8 ounces of liquid is consumed that is caffeine free. Sometimes the staff does not document right away but do so before their shift is over. As long as the liquid is non caffeinated they do not need to document each type of liquid. Staff is to encourage Resident #2 to drink water but sometimes Resident #2 would prefer something else.</p> <p>Resident #2's program to increase sign language skills is informal and therefore not tracked or documented. The facility manager will provide an in-service on Resident #2's sign language skills at the next team meeting on 1/14/14. Going forward staff will encourage Resident #2 to use these signing skills but they are not required to document because it is an informal program.</p> <p>W 113-227</p> <p>The previous QIDP was removed from this position. The new QIDP will stay current on all procedures related to the QIDP position, including completion, revision, updates of consents, releases, CFA's, Objectives, IPP's and PBSP's and semi-annual Q reviews. The QIDP will also set up a calendar for when semi-annual reviews are due for each resident to ensure that the reviews get completed on time by 1/14/14.</p>		

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W 227	Continued From page 13 encouraging Resident #2 to eat slowly on a daily basis. a. During observation of the afternoon snack on 11/18/13 it was noted that staff did not sit with resident nor did they give any guidance for him to slow his eating down. 3. Learn to Put Dirty Laundry in Hamper: First noted 11/01 and started 07/10/13. This objective was to be tracked on a semi-annual schedule. The objective stated that Resident #2 would independently put his dirty clothing in his hamper after showering/bathing 75% of the time. The plan stated Resident #2 ' s hamper should be in his bedroom, unless he continued to remove dirty clothing to wear or put clean clothing in the hamper with the dirty clothes and if this was the case, the hamper was to be moved to the laundry room and staff were to attempt to put it back in Resident #2 ' s bedroom in next few months. Also the plan stated Resident #2 ' s day to do his laundry was Monday, however upon review of the Laundry day list, Resident #2 ' s name was not on it. a. Observation during facility rounds on 11/17/13 and 11/19/13 revealed that a hamper was not in resident ' s room or laundry room for Resident #2 although staff were documenting three days a week that Resident #2 placed his clothes in his hamper. 4. Obtain a Low-Calorie Snack: First noted 07/06 and started 07/10/13. This objective was tracked semi-annually. The objective stated that Resident #2 would independently obtain a low-calorie snack for his lunch on 5 out of 5 consecutive trials by 07/10/14 and was met on 10/13/11. The Plan stated that staff were to follow program located in program book and document on achievement sheet and on program data sheet 3 times weekly; encourage to obtain a	W 227			

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W 227	Continued From page 14 healthy snack every time he makes his lunch and at other times when he so desires. Documentation on the tracking form for October 2013 did not address the cueing level that was needed by Resident #2 to obtain the low calorie snack. Staff had been marking check marks in the cueing section. 5. Non-caffeinated beverages to total 64 oz. daily: Staff were to document with initials each time 8 oz. of liquid was consumed on one form and on another form staff were documenting a check mark for the amount of liquid consumed. It was difficult to verify how much liquid or what type of liquid was actually consumed on any given day. During observation on 11/17/13 and 11/18/13, Resident #2 was observed drinking a large bottle of soda pop and a glass of water. Resident #2 also was observed dumping a glass of water into the sink and sneaking a partially filled can of soda, none of which were recorded. Resident #2 has a communication objective: 1. Increase Sign Language Skills: First noted 09/92 and started 07/10/13. The plan states staff were to encourage Resident #2 to use his signs during his daily routine and praise him for using his appropriate modes of communication (gestures, facial expressions, speech, signs, etc.). Resident #2 showed preference to non-verbal communication. Staff documented on Resident #2 's communication/signing on a daily basis and were to encourage the words when applicable: pop, shower, swim, van ride, eat, meds, work, toilet, and help. However there was nowhere for staff to document this information.	W 227			
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by	W 339	W 339 The facility manager will change Resident #1's fluid intake sheet to read 67-101 ounces daily by 1/8/14 and go over the sheet with staff at the next staff meeting on 1/14/14. Going forward the QIDP will review all RN quarterlies and highlight areas that need to be followed up by the facility manager. The facility manager then will give the quarterlies back to the QIDP within two weeks from receiving it from the QIDP with all of the recommendations followed up on and signed and dated starting 1/31/14.		

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W 339	<p>Continued From page 15 client needs.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, facility failed to follow the nursing treatment plan for 1 of 3 sampled residents (Resident #1) in receiving their recommended fluid intake. This failure placed resident at risk of having kidney complications and further deterioration of Resident #1 ' s health. Findings include: All record reviews and interviews were conducted between 11/17/13 and 11/19/13 unless otherwise specified. Record review of Resident #1 ' s RN Quarterly Physical Assessment dated 09/04/13 revealed in 05/2013 Nephrologist recommended at least 67 to 101 oz. fluids daily; an increase from the previous 48-64oz., preferably water for optimal kidney function. RN Quarterly Assessment (09/04/2013) section titled Attention Required/Follow-Up revealed: " As for her kidney function, please continue to encourage fluids, especially now that her requirement has increased from 48-64 oz. to 67-101 oz. fluids per day " Interview with Staff A and B acknowledged they were unaware of the increased fluid requirement for Resident #1. The facility uses a form titled " Fluid Intake Record " which lists fluid amounts of 8 oz., 16 oz., 24 oz., 32 oz., 40 oz., 56 oz., up to 64 oz. per calendar day of the month. Staff documented with a check mark the corresponding amount of fluid a resident consumed for the day. Record review of Resident #1 ' s Program Book revealed the Fluid Intake Record for November 2013 (November 1st through 17th) staff</p>	W 339			

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W 371	Continued From page 17 while taking the medications. The retrieving and putting away of medications and the getting the water for the resident diminished the ability of Resident #4 of becoming independent with her self-medication. Interview with Staff A revealed that the staff got the medication down for the residents because of the location of the medication in the room. Medication was stored in a locked cupboard above the sink in the laundry room. On the counter angled with a nozzle in the sink is a large jug of Elimo (a deodorizing agent) liquid with a laptop computer sitting on top of it. Next to the lower cabinets below the sink was a 2 drawer file cabinet that would make it difficult for 2 of the 5 residents (Resident #1 & 5) in the facility to reach their medication baskets without having to lean over file cabinet and reach above laptop positioned on top of the jug of Elimo. Staff A agreed that this was a problem and stated that they would look into rearranging the room to allow for residents easier access to their medications.	W 371			
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, record reviews and interviews, facility failed to provide specially prescribed diets to 1 of 3 sampled residents (Resident #1) and 1 of 2 expanded sample residents (Resident #5). This failure to provide a specially prescribed diet placed residents at risk of potential health problems.	W 460	W 460 All 5 residents were assessed by the consulting dietician on December 5, 2013. The facility manager will go over the recommendations for all residents at the next staff meeting on 1/14/14. We are consulting with a new dietician to update our menu to meet the dietary needs of all residents and will have this in place by 1/31/14. Going forward the QIDP will review all assessments and highlight areas that need to be followed up by the facility manager. The facility manager then will give the assessments back to the QIDP within two weeks from receiving it from the QIDP with all of the recommendations followed up on and signed and dated starting 1/31/14.		

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W 460	<p>Continued From page 18</p> <p>Findings include: All record reviews and interviews were conducted between 11/17/13 and 11/19/13 unless otherwise specified.</p> <p>Over a three day period, staff were observed to prepare and serve meals to the residents. Food items prepared were not measured to reflect caloric intake recommended and dietary restrictions as recommended on Quarterly Nursing Assessment dated 09/04/13 for Resident #1 and Quarterly Nursing Assessment dated 10/09/13 for Resident #5.</p> <p>Resident #1</p> <p>Record review of RN Quarterly Nursing Physical Nursing Assessment dated 09/4/13 revealed Resident #1 has the following health conditions: 3</p> <p>Record review of RN Quarterly Assessment dated 09/04/13 revealed Resident #1 is edentulous; on a mechanically soft diet, limited caffeine and all meats finely ground or finely cut. Total calorie intake of 1800 calories. In Staff Program Book, instructions from Evergreen Home Health (dated 05/20/03) provided the following instructions: soft, (preferably moist), chewable, dissolving-style crackers (Ritz, Saltine). No hard-style crackers.</p> <p>Observation of lunch meal on 11/18/13, served to Resident #1 included a tuna fish sandwich cut up into bite sized chunks, small hard style animal cookies and small cut up apple pieces.</p> <p>Interview with Staff F revealed he was unaware of what foods Resident #1 should avoid, and</p>	W 460			

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W 460	<p>Continued From page 19 provided State Surveyor with " Chronic Kidney Disease Diet " .</p> <p>Resident #5</p> <p>Record review of RN Quarterly Nursing Physical Nursing Assessment dated 10/09/13 revealed Resident #5 has a history of the following health conditions: 3 Recent issues noted on RN Quarterly Nursing Assessment dated 010/09/13 revealed lab work on 08/22/13 noted triglycerides very high at 240 (should be < 150); HDL is low at 29 (>40). Blood glucose was high at 155 (<100). Resident #5 had not fasted prior to labs, so all these values could have been skewed negatively. RN noted: In effort to obtain ideal body weight as well as to maintain her LDL status, Resident is restricted to a low fat, low cholesterol, and high fiber diet.</p> <p>Record review of RN Quarterly Assessment dated 10/09/13 revealed: Resident #5 is on a 1200 calorie, high fiber, low cholesterol, low fat diet; has been gaining weight and is now 23 pounds over her ideal body weight parameters; RN noted on 10/09/13: " Please adhere strictly to her parameters for a high-fiber diet, filled with fresh, perishable fruits. Cooking meals " from scratch " rather than relying on packaged meals to which ingredients are added will help reduce any inflammation that contributes to this higher weight despite a daily intake of 1200 calories " .</p> <p>Record review of facility menu book revealed portion sizes were based on 1500, 1800 and 2000 calorie recipes. The menu book did not have 1200 calorie recipe for facility staff to follow. However, notes on menu revealed: " 1200</p>	W 460			

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W 460	Continued From page 20 calorie: 1500 calories less a starch (bread, potatoes, rice, muffin, etc.) at EACH meal " .	W 460			
W 481	Interview with Staff F revealed the menu book is not always followed for breakfast and lunch meals. However, the facility does adhere to the dinner menu, if ingredients are available. 483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews the facility failed to keep menus of food actually served to 3 of 3 sampled (Resident #1, #2 and #3) and 2 of 2 expanded sample residents (Resident #4 & #5) on file for 30 days. This failure placed residents at risk of compromised nutritional health when the facility was unable to identify what food items were served to residents. Findings include: All observations, interviews and record reviews were conducted between 11/17/13 and 11/19/13 unless otherwise specified. Observations over a three day period, staff were observed to prepare and serve meals to the residents that were not part of the written menu book. Record review revealed a menu book which provided the facility with 12 months of daily menus for each meal: breakfast, lunch, dinner and snacks. The menu book revealed lunch on 11/18/13 included: peanut butter sandwich, raw vegetables, apple and fruit juice. Observation revealed staff prepared a tuna fish sandwich with apple sauce, animal crackers and a cream soda beverage for Resident #1. Resident #4 was	W 481	Starting 1/8/13 staff will document all menu substitutions and keep these on file for 6 months. The facility manager will review these weekly to ensure that they are being done. Going forward we are consulting with a new dietician to update our menu to meet the dietary needs of all residents and will have this in place by 1/31/14.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2013
NAME OF PROVIDER OR SUPPLIER CHELSEA GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 26511 NE VIRGINIA ST, PO BOX 1394 DUVALL, WA 98019		
(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 481	<p>Continued From page 21</p> <p>observed eating a sandwich that she had purchased the day before from Subway and Resident #2 was observed eating a baked potato as his snack.</p> <p>Interview with Staff F revealed the menu book is not always followed for breakfast and lunch meals. However, the facility does try to adhere to the dinner menu, if ingredients are available.</p> <p>Interview with Staff A revealed staff were expected to follow the menus when preparing meals for residents and document any substitutions. Staff A indicated that when substitutions are made they were to be documented on the substitution list in the menu book. However, there were no substitutions documented for the lunch meal on 11/18/13. The meal substitution list revealed 18 dinner substitutions and no substitutions for breakfast and lunch meals from 1/17/13 through 11/19/13.</p> <p>Facility was asked for a copy of their 30 day menu of food actually served to residents. Staff A revealed the facility did not have a process in place for keeping 30 days of menus on file for the foods actually served.</p>	W 481			



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Residential Care Services
PO Box 45600, Olympia, WA 98504-5600

Statement of Deficiencies/ Plan of Correction Page 1 of 3	License# 669 Chelsea	Completion Date: 11/19/13
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You are required to be in compliance at all times with all laws and regulations to maintain your boarding home license.

The department has completed data collection for the unannounced on-site inspection on 11/17/13 thru 11/19/13 of:

Chelsea Group Home
26511 NE Virginia Street
Duvall, WA 98019

The following sample was selected for review during the unannounced on-site visit: 3 of 5 residents.

The department staff that inspected/investigated the boarding home:
Janette Buchanan, BSN
Claudia Baetge, MA

From:
DSHS, Aging and Disability Services Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

As a result of the on-site visit(s), the department found that you are not in compliance with the laws and regulations as stated in the cited deficiencies in the enclosed report.

Paula Sofia Lozada Baniqued
Residential Care Services

12/13/13
Date

I understand that to maintain a boarding home license I must be in compliance with all of the laws and regulations at all times.

Samuel P. [Signature]
Administrator (or Representative)

12/27/13
Date

WAC 388-78A-3090 Maintenance and Housekeeping

(1) The boarding home must:

- a) Provide a safe, sanitary and well maintained environment for residents;
- b) Keep exterior grounds, boarding home structure, and component safe, sanitary and in good repair;
- c) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition.

This requirement was not met as evidenced by:

Findings include:

All observations occurred between 11/17/13 through 11/19/13, unless otherwise noted.

- Outdoor light was not working which resulted in a darkened area near facility entrance.
- Carpeting in the living room floor was stained. Carpeting throughout the rest of the facility was soiled and dirty with small stained areas.
- Doorknob on door leading to the stairwell was loose and not securely fastened.
- Base of stairwell and landing area had ¾" rough edge plywood panels nailed to wall to cover holes in the sheetrock.
- Resident #2's bedroom had ¾" rough edged plywood panels nailed to the wall (approximately 13 feet long by 4 feet high) to cover holes in sheetrock and a baseball size hole in the wall near the head of bed that had not been repaired with flaking paint and sheetrock pieces on the floor.
- Resident #5's bathroom ceiling had black spots that appeared to be mold and bubbling/blistering paint approximately 1½ - 2 feet long.

Staff A revealed work orders had been previously submitted for the following: carpet cleaning submitted on 10/17/13, doorknob replacement on 09/28/13 and repair wall in Resident #2's bedroom submitted on 09/05/13 and 09/06/13. Interview with Staff A revealed work to have items cleaned/repared have not been completed.

Plan of Correction:

Date Completed:

1. The facility's maintenance supervisor will replace the outdoor light near the facility entrance by 1/8/14.
2. The carpeting in the living room and common areas was cleaned on 12/16/13.
3. The doorknob on the door leading to the stairwell was loose and not securely fastened was repaired by the maintenance supervisor on 11/19/13.
4. The maintenance supervisor will sand and paint the plywood that is on the base of the stairwell and landing area by 1/15/14.
5. The plywood panels that are nailed to the wall in Resident #2's bedroom were removed, the holes in the sheetrock were repaired on 12/26/13, and the bedroom will be painted by the maintenance supervisor by 1/31/14.
6. The facility's maintenance supervisor will repair the damaged ceiling in Resident #5's bathroom and remove any possible mold by 1/17/14.

In future the facility manager and QIDP will comply with state regulations related to providing a well repaired and maintained environment which is free from safety hazards by doing a monthly walk through of the facility starting January 2014.