

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

PRINTED: 08/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 17235 126TH PLACE NORTHEAST WOODINVILLE, WA 98072	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an Annual Recertification Survey conducted at Brookhaven Group Home on 07/12/14 to 07/17/14. A sample of three residents was selected from a census of five. The expanded sample included two current residents.</p> <p>The survey was conducted by: Janette Buchanan, R.N., B.S.N. Terry Patton, R.N., B.S.N.</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 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents,</p>	W 104		

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DSSS-ADSA
Residential Care Services
ICF/MR Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Janette Buchanan* TITLE **ED** (X6) DATE **9/9/14**

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

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W 104	<p>Continued From page 1</p> <p>visitors and staff have a designated area to smoke. This failure placed residents, visitors and staff at risk of inhaling second hand smoke, potentially causing life threatening illnesses.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>Observations repeatedly revealed Residents #1, 2 and 4 sat approximately four feet outside the main entrance to the facility and smoked cigarettes. The entrance alcove, where the residents smoked, was enclosed on three sides and had a roof over it, which held the smoke in the alcove. Anyone entering or leaving the facility would walk within two feet of the person smoking the cigarette and could not avoid inhaling the cigarette smoke.</p> <p>Interview with staff revealed residents prefer to sit in an enclosed entrance area to smoke to be out of the weather. Staff A, D, E, and F stated they do not like having to walk through cigarette smoke when entering or leaving the facility.</p> <p>Review of RCW 70.160.020 (2) " Public place " means that portion of any building or vehicle used by and open to the public, regardless of whether the building or vehicle is owned in whole or in part by private persons or entities, the state of Washington, or other public entity, and regardless of whether a fee is charged for admission, and includes a presumptively reasonable minimum distance, as set forth in RCW 70.160.075, of twenty-five feet from entrances, exits, windows that open, and ventilation intakes that serve and</p>	W 104	<p>W104</p> <p>Based on the information provided and our investigation into this citation clients will be informed that there will be a change in protocol which is that cigarettes must be smoked 25 feet from the entrance of the facility. Clients will be given until Sept 8th to process/question this change in policy. Umbrellas have always been provided for those that smoke, and we have had recent conversations about a "smoke" shack for the Brookhaven clients.</p> <p>The facility manager will be responsible to ensure staff and clients are adhering to this change in policy.</p> <p>The QIDP will in essence be able to monitor compliance each time I walk through that door because I will either see clients there smoking or not. I walk through that door several times a day. Completion by 9/8/14.</p>		

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W 104	Continued From page 2	W 104			
W 109	<p>enclosed area where smoking is prohibited. A public place does not include a private residence unless the private residence is used to provide licensed child care, foster care, adult care, or other similar social service care on the premises.</p> <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 sanitation.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to comply with State Regulations (WAC 388-78A-2305) to ensure dishes and utensils used by 3 of 3 sampled residents (Resident #1 , 2, & 3) and 2 of 2 expanded sample residents (Resident #4 and 5) were sanitized when washed in the facility ware washer. This failure placed residents ' health at risk from using dishes and utensils which may be contaminated.</p> <p>Findings include:</p> <p>All observations and interviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>WAC 388-78A-2305 requires facilities to comply with WAC 246-215. WAC 246-215-04545 requires hot water in the type of warewasher used by the facility to be a minimum of 150 degrees</p>	W 109			

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W 109	Continued From page 3 Fahrenheit, unless a sanitizer meeting the requirements of WAC 246-215-04565 was used. Refer to attached statement of deficiencies dated 07/17/14 for details of failed practice under WAC 388-78A-2305, WAC 246-215- 04545 and WAC 246-215- 04565.	W 109	W109 We have thermometers that hold the highest temperature the dishwasher reaches during its cycle. The thermometer turns black if the dishwasher reaches 150 degrees. The facility will use these thermometers once a month to check and see if the dishwasher is reaching the required temperature.		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the active treatment program for 1 of 3 sampled residents (Resident #3) was integrated, coordinated and monitored by a Qualified Intellectual Disability Professional (QIDP). Failure to integrate, coordinate and monitor active treatment programs could result in a resident having a decline that was not monitored. Findings include: All observations, interviews, and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Resident #3 Observation of Resident #3 revealed Resident #3 talking with staff, residents, and surveyors, talking on the phone to friends and family, assisting with making the meals when it was his turn, and going	W 159	If the dishwasher does not reach the required temperature a maintenance requested will be made and the maintenance person will repair, fix or replace the dishwasher to a state that it is once again meeting the standard. The facility manager will ensure the monthly dishwasher temperature checks and documentation are done consistently. The QIDP will check compliance during our Monday morning walkthroughs, monthly. Completion by 9/1/14. W159 Resident #3's money counting objective has been started and compliance continues to be consistent since staff started doing the program. His CFA will state that he is in need of increasing his abilities in counting change; and that he would prefer to count real money and not the paper worksheets we have provided him. The QIDP when testing/getting baseline data for residents will ensure information retrieved from this process finds its way into all parts of the residents IPP.		

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W 159	<p>Continued From page 4 on walks with staff. Resident #3 also would go to the kitchen for snacks as earned throughout the day.</p> <p>Record review revealed Resident #3 had a [REDACTED] and [REDACTED]. He was admitted to the facility on [REDACTED] 13.</p> <p>Review of Resident #3 ' s Comprehensive Functional Assessment (CFA) dated 06/01/13 . revealed Resident #3 ' s CFA did not have any problems with his money skills.</p> <p>Review of Resident #3 ' s Individual Program Plan (IPP) dated 04/30/13 revealed the Individual Program Plan (IPP) identified Objective #1404 - Counting Change, as a problem area for resident if he were to go back into the community. On the 03/01/13 -08/31/13 Qualified Intellectual Disability Professional ' s (QIDP) semi-annual summary identified Resident #3 as needing to independently count/add up change 10 out of 10 consecutive opportunities by September 2014. However, from September 2013 to March 2014 no data for the Counting Change program was obtained and documentation notes the program was not initiated until March 2014.</p> <p>Review of Resident #3 ' s QIDP semi-annual summary documentation by Staff A revealed Staff A and B tested Resident #3 on various skills which would increase his independence and improve his self-management skills in the community and found that Resident #3 was in need of increasing his abilities in counting change.</p> <p>Interview with Resident #3 revealed he did not</p>	W 159	<p>The facility manager at a monthly team meeting will ensure that all Staff are aware on the new objective and the importance of objective starting ASAP.</p> <p>The lead staff at Brookhaven has the responsibility to ensure programs/objective are done consistently which would include that programs/objectives are started shortly after the QIDP updates a client's IPP.</p> <p>The QIDP will be responsible to ensure that programs/objective are started no later than the first mandatory meeting after it has been added to the resident program book. Completion by 9/19/14.</p>		

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W 159	Continued From page 5 want to talk about program, however did share he did not like counting the paper money. Resident #3 stated he would rather count real coins and not just the coins printed on paper.	W 159	W227 Resident number 4's CFA will be updated to reflect that there are concerns with her toileting outside the facility and clogging the toilets at the facility. Based on my investigation she has never urinated inappropriately while at work or on walks so at this time there are no concerns with "community placement".	
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, interview, and record review, the facility failed to ensure Comprehensive Functional Assessment (CFA) identified inappropriate toileting as a specific problem for 1 of 2 expanded sample residents (Resident #4). Failure to identify Resident #4 's inappropriate toileting behavior possibly could result in not meeting community placement criteria. Findings include: All observations, interviews, and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Observation on 07/12/14 revealed Resident #4 having gone out in front of facility and urinating. Resident #4 then re-entered facility and was confronted by staff as to why she had done so. Resident #4 started yelling at staff and crying and	W 227	The QIDP will inform the consulting behavioral specialist to help understand these behavior as it pertains to Resident #4 and any others that exhibit these or similar behaviors. Generally a plan is created by the behavioral specialist to replace, eliminate or significantly decrease these behaviors for all affected. Once the plan is in place to reduce, eliminate decrease significantly this data will be given to the behavioral specialist and the plan then left as is if it is effective or tweaked if not effective until satisfactory result are obtained from the data collected. The QIDP will be responsible to ensure the behavior specialist is aware of all behaviors that require his attention and that the data is collected consistently to help him make appropriate decisions when it comes to objectives, and or plans to decrease or eliminate behaviors. Completion by 9/30/14.	

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W 227	Continued From page 6 reported her toilet in her bathroom was not working and she had to go to the bathroom, therefore she had to urinate outside. Review of Resident #4 ' s CFA dated 02/24/14 revealed Resident #4 was independent with toileting and had no concerns. Comprehensive Functional Assessment did not address Resident #4 ' s clogging toilets or inappropriately toileting outside. Interview with Resident #4 revealed she has reported her toilet as being broken (clogged) numerous times and does not feel staff are responding to her. Interview with Staff C revealed Resident #4 has had issues with clogging of toilets and inappropriate toileting. Staff C stated Resident #4 ' s toilet was working and plugging toilets and toileting outside were problem behaviors by Resident #4. Interview with Staff A and B regarding Resident #4 ' s toilet not working revealed Resident #4 ' s toilet did work, however she continued to clog her toilet and those of other facility residents. Staff A stated facility staff frequently checks Resident #4 ' s toilet to ensure it is in working order. Staff A and B also revealed they were unaware Resident #4 had been going outside to urinate or that staff reported Resident #4 ' s toileting outside as a common behavior. Staff A revealed Resident #4 did not have an assessment directed at getting her to stop clogging toilets and/or urinating outside.	W 227		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE	W 257		

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W 257	<p>Continued From page 7</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record reviews and interview, the facility failed to monitor and change the Active Treatment Program interventions for 1 of 3 sampled residents (Resident #2). Failure to monitor and change the interventions of an Active Treatment Program for a resident who has shown loss of functioning decreases the ability of the resident to develop independence and places the resident at risk for diminished quality of life.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>Resident #2</p> <p>Observation of Resident #2 and facility staff interactions with Resident #2 did not reveal Resident #2 cleaning her room when asked to by facility staff. Resident #2 was observed in the kitchen obtaining food and beverages. Resident #2 was also observed outside walking and carrying a satchel to a car. Resident #2 was also observed smoking cigarettes, eating, walking and socializing.</p> <p>Record review revealed Resident #2 had a [REDACTED] an [REDACTED]</p>	W 257	<p>W257</p> <p>Resident #2 is capable of cleaning her room however she has not shown the ability to consistently keep her room safe and free of potentially harmful clutter should an emergency arise. The objective to keep her room clean and clutter free with a path to the door is a direct result of citation received.</p> <p>Going forward if Resident #2 refuses to clean her room Staff will straighten her room, ensuring it is free of clutter and there is a path to the door for emergencies. These changes to the objective will be updated throughout her IPP. If at any time she maintains her room in a clutter free safe state for 3 months the objective will be stopped and another started.</p> <p>Data is to be collected for compliance and refusals weekly. The effectiveness of this objective is to be assessed at least semi-annually.</p> <p>The QIDP will be responsible to ensure that the objective is updated and or changed as needed.</p> <p>Completion by 9/19/14.</p>		

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W 257	Continued From page 9 room cleaning performance. Staff A, B, and C acknowledged Resident #2 did not clean her room when asked by facility staff and, therefore, did not comply with her Active Treatment Program.	W 257	W259 Resident #2's CFA will be updated and reflect changes that have occurred during the course of the year.		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to review the Comprehensive Functional Assessment (CFA) and determine if the Individual Program Plan (IPP) was relevant for 1 of 3 sampled residents (Resident #2). Failure to annually review resident 's CFA resulted in an unchanged CFA which did not reflect resident changes since the last CFA and resulted in an ineffective Active Treatment Program. Findings include: All interviews and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Resident #2 Review of Resident #2 's Comprehensive Functional Assessment (CFA) revealed Resident #2 's CFA, dated 05/23/13, had not been updated for more than a year. The 05/23/13 CFA did not reveal a need for Resident #2 to clean her room. However, the facility had only one formal Active	W 259	It is the responsibility of the QIDP to ensure all relevant changes for all residents are reflected in the resident's CFA. The QIDP uses data collected on site and information received from the resident, Staff, worksite and the professionals that are employed as consultants to ensure he has a complete picture from all aspects of the resident's life which in turn will ensure every client's CFA represents all change to resident during the year. The QIDP will ensure, that per the schedule of each Client's IPP which is compiled annually that he will using this schedule have each Clients IPP completed with 30 days of the date of the Resident's IPP. Currently the Executive Director has been requesting that we email our Semi-Annuals and IPP's to her and in turn she will insure compliance. All resident CFA's will be up to date by 9.30.14. The QIDP is responsible for ensuring that Client IPP's are up to date and accurate at all times for all residents. Completion by 9/30/14.		

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W 259	Continued From page 10 Treatment Program for Resident #2 and that was for cleaning her room. Review of Active Treatment Program data revealed Resident #2 had not cleaned her room when asked to by the facility staff in more than two months. Staff A verified Resident #2 's current CFA was dated 05/23/13. Staff A revealed the facility had recently hired a new specialist to develop and write the CFA 's for facility residents and a new CFA for Resident #2 would soon be completed.	W 259		
W 313	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to perform a risk benefit assessment to determine whether the harmful effects of the behavior outweigh the potentially harmful effects of the medications. This failure placed Resident #1 at risk of taking medications which potentially may cause harm to the resident. Findings include: All observations, record reviews and Interviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Observation of Resident #1 at 7:10 AM on 07/13/14 revealed she self-administered medications which included [REDACTED] 75 mg.	W 313		

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W 313	Continued From page 11 and [REDACTED] 100mg. Review of Resident #1 ' s Physician ' s Orders revealed Resident #1 was prescribed [REDACTED] ER 75 mg. to take each morning for [REDACTED] [REDACTED] 100mg. each morning and evening for [REDACTED] each evening for [REDACTED]. Interview with Staff A revealed the facility had not done an assessment of Resident #1 ' s medications to determine if the positive changes in Resident #1 ' s behaviors outweighed the potential harmful effects of the medications.	W 313	W313 Resident #1 will have a "risk benefit assessment" to determine if taking the medications she takes causes more risk than the behaviors the medication are prescribed for. All Residents at Brookhaven will have the assessments done soon and annually. All residents who take [REDACTED] medications will have their assessments annually to coincide with their IPP.
W 317	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. This STANDARD is not met as evidenced by: Based on observation, records review, and interview, the facility failed to implement a drug reduction program for medications or to document the clinical need for the drugs as prescribed. This failure puts the Resident #1 at risk for potential harm due to possibly taking excessive and unnecessary amounts of these medications. Findings include: All observations, record reviews and Interviews were conducted at the facility from 07/12/14	W 317	The facility manager will ensure that these assessments are happening annually and will use the form we already have to get the assessment completed at each client's next [REDACTED] appointment. Completion by 9/19/14. W317 Resident #1 will have her [REDACTED] medications "gradually reduced unless clinical evidence justifies that this is contraindicative" at her next scheduled [REDACTED] medication appointment. All residents who take psych medications will have their medications assessed for appropriateness annually to coincide with their IPP. The facility manager will ensure that these assessments are happening annually and will use the form we already have to get the assessment completed at each client's next Psych appointment and then annually at the closest next appointment to the residents IPP. Completion by 9/19/14.

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NAME OF PROVIDER OR SUPPLIER BROOKHAVEN GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 17235 126TH PLACE NORTHEAST WOODINVILLE, WA 98072		
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W 317	Continued From page 12 through 07/17/14 unless otherwise stated. Observation of Resident #1 at 7:10 AM on 7/13/14 revealed she self-administered medications for [REDACTED] control which included [REDACTED] 75 mg. and [REDACTED] 100mg. Review of Resident #1 's Physician 's Orders revealed Resident #1 is prescribed [REDACTED] 75 mg. to take each morning for [REDACTED] 100mg. each morning and evening for [REDACTED] and [REDACTED] 100 mg each evening for [REDACTED]. Interview with Staff A revealed the facility had not implemented a planned reduction program of Resident #1 's medications. Also, the facility had not documented the clinical need for the dosage and frequency of these medications as prescribed.	W 317	W322 4 residents have completed their annual history and physical. A 5 th resident (TS) refused to go to the appointment this appointment has been rescheduled. The facility manager now has at his desk a document that states when the next annual history and physical is due for each resident and will schedule each appointment as they come due. The plan to ensure follow up appointments are not missed is as follows; the facility manager has put a clip board on the wall that Staff are to copy and put all doctor visit forms on that require follow up. The original one is to be filed in the resident's medical book. This ensures that the facility manager is aware and can schedule the follow up appointments.		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 3 sampled residents (Resident #1) had an appointment six months after her Annual Physical as directed by the Physician and also failed to ensure an Annual Physician Assessment was completed for 1 of 3 sampled residents (Resident #3). Failure to ensure residents had an Annual Physician Assessment or follow up on Physician 's order to have a repeat examination may result in a	W 322	The facility manager is responsible to ensure that client annual physicals are scheduled and completed with documentation on site available to all who may need to review it. The QIDP is ultimately responsible to ensure that the facility manager consistently follows the plan which ensures client annual appointments and follow up appointments are made. Completion by 9/19/14.		

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W 322	Continued From page 13 deterioration of the residents overall health and well-being. Findings include: All interviews and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Resident #1 Review of records revealed Resident #1 was to have a follow up physician ' s appointment 6 months following her Annual Physician ' s appointment of 11/12/13. Documentation revealed Resident #3 had not visited a physician since 11/12/13. Interview with Staff A and B revealed they were unaware Physician ' s order for Resident #1 indicated she was to have a follow up appointment within 6 months of the 11/12/13 Annual Physical and acknowledged Resident #1 had not visited the Physician since her 11/12/13 visit. Resident #3 Review of records revealed Resident #3 ' s last Annual Physician Assessment was on 04/25/13. Interview with Staff A and B revealed Resident #3 ' s Annual Physician Assessment had not been done since Resident #3 ' s 04/25/13 Admission Physical Assessment.	W 322		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical	W 323		

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W 323	Continued From page 14 examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 2 expanded sample residents (Resident #4) received an annual and/or as recommended audiology examination. Failure to provide a timely exam placed resident at risk of unidentified changes in hearing and/or other medical issues which could lead to deterioration in her overall health. Findings include: All interviews and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated. Record review for Resident #4 revealed no documentation she ever had an audiology exam. Interview with Resident #4 revealed she could not recall whether she had a hearing exam in the past or not. Interview with Staff A and B revealed they were unaware residents needed an audiology exam if their hearing appeared adequate.	W 323	W323 All residents but one went to all scheduled appointments to get the facility back in compliance. There are some appointments still to come however. The facility manager has on his desk a documents that shows when each individual residents last appointment was for their individually needed examination (ex. audiological, vision, etc.) and when the next one should be scheduled. The QIDP will be responsible to ensure that the facility manager continues to stay up to date with each individual client's annual evaluation / examinations. Completion by 9/1/14.		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by:	W 368	W368 All physician orders are current and on site. The consulting RN will email the facility manager and QIDP stating that physician orders are due. The facility manager will update physician orders and then email to consulting RN who prints, corrects if needed, signs, then scans and sends back to the facility manager. Who then prints them and sends hardcopies to each residents PCP for the doctors signature. The QIDP will be responsible to ensure the facility manager completes the steps above and the physicians orders are signed and on site for all who need to review. Completion by 9/8/14.		

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W 368	<p>Continued From page 15</p> <p>Based on observation, record review and interviews, the facility failed to ensure 2 of 3 sampled residents (Residents #1 and #2) and 2 of 2 expanded sample residents (Residents #4 and #5) had current, valid Physician 's Orders. Failure to ensure Physician Orders are current placed residents at risk of taking unnecessary medications the Physician may have discontinued and/or not receive necessary new medications which may be prescribed by the Physician.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>Observation during the morning of 07/13/14 revealed Residents #1, 2, 4 and 5 self-administered their medications. Staff I was observed assisting residents and documenting the medications the residents self-administered onto a Medication Administration Record (MAR). Review of the Medication Administration Record (MAR) and comparison of the MAR to the Physician 's Orders revealed the medications self-administered by the residents were taken at the dosage and time ordered in the Physician 's Orders for each resident.</p> <p>However, review of the Physician 's Orders for Residents #1, 2, 4 and 5 revealed the Physician signed the medication and treatment orders on 02/27/14. The start dates for those medications and treatments ordered by the Physician was 03/01/14. The date to end those medications and treatments in the Physician 's Orders was 05/31/14. The residents ' records did not reveal any Physician 's Orders reordering medications</p>	W 368		

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W 368	Continued From page 16 and treatments for Residents #1, 2, 3 and 4 after 05/31/14. Interviews with Staff A, B and J revealed that each resident have their medication orders renewed by the Physician every ninety days. Staff B failed to write the ninety day orders which were to be effective from 06/01/14 to 08/31/14. This failure prevented physician from reviewing and signing orders that were to begin on 06/01/14 Facility staff helping residents to self-administer medications failed to note the Physician ' s Orders ended May 31, 2014, and staff continued to assist residents to take their self-medications in June and July of 2014. Interviews with Staff A, B and J revealed the facility procedure for renewing Physician ' s orders was not followed. Interviews with Staff A, B, and J also revealed the facility had no system to ensure Physician ' s Orders were renewed.	W 368		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure fire drills were conducted for each shift of personnel. This failure placed 3 of 3 sampled residents (Resident #1, 2, and 3) and 2 of 2 expanded sample residents (Resident #4 and 5) and staff at risk of harm from potential entrapment. Findings include:	W 440		

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W 440	<p>Continued From page 17</p> <p>All interviews and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>Review of facility fire drill records between July 2013 and June 2014 revealed no documentation showing fire drills were conducted during the months of January, February, and March 2014 for any shift.</p> <p>Interviews with Staff A and B revealed the facility had failed to consistently conduct monthly fire drills on each shift.</p>	W 440	<p>W440</p> <p>During the next mandatory Staff Meeting staff will be informed that Fire Drills need to happen during each shift as documented. The shifts are as follows: 8 – 3; 3 – 10; 10 – 8.</p> <p>The facility manager has written a reminder for staff to conduct the Fire Drill for each month of the current year on the staff calendar and his person calendar. The reminder specifies which shift, the date and time for staff to conduct the fire drill.</p> <p>There are now two opportunities for a missed or incorrect fire drill to be caught and revised or reminded of.</p>	
W 441	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review, facility failed to ensure evacuation routes varied during evacuation drills for all residents on all shifts. This failure placed residents and staff at risk of harm should an emergency occur that necessitated evacuation of the facility.</p> <p>Findings include:</p> <p>All interviews and record reviews were conducted at the facility from 07/12/14 through 07/17/14 unless otherwise stated.</p> <p>Review of facility Fire Drill records revealed fire drill records did not indicate which alarm pull station sites were used to initiate the drills and/or the evacuation routes the residents took during the drills.</p>	W 441	<p>The QIDP has on his electronic calendar created a reoccurring reminder to ask the Facility Manager has the Fire Drill happened and is it during the right shift every month about a week and a half before the end of the month. This gives the facility time to make corrects if needed. Completion by 9/19/14.</p> <p>W441</p> <p>All staff retrained to indicate on the fire drill form which pull station was used, which route was used by each resident and a detailed description of where the meeting place is.</p> <p>Staff will also position themselves in different positions throughout the facility during each fire drill to simulate that a fire has blocked an exit so clients and staff must use alternative exits.</p> <p>The facility manager will be responsible to train staff and clients so all aware of the expectations and changes to protocols during fire drills. Completion by 9/19/14.</p>	

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W 441	Continued From page 18	W 441		
W 454	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure appropriate infection control practices were followed to prevent and limit the spread of infections while preparing meals in the kitchen for 1 of 3 sampled residents (Resident #3) and 2 of 2 expanded sample residents (Resident #4 and 5). This failure placed residents at risk for potential exposure to a communicable disease and/or risk to compromised health.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were conducted at the facility from 7/12/14 through 7/17/14 unless otherwise stated.</p> <p>Observation during meal preparations in the facility 's kitchen revealed Residents #3, 4, and 5 prepared food for self and others with obvious open sores. Resident #3 was observed with a</p>	W 454		

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W 454	Continued From page 19 sore to the left of his mouth, Resident #4 had numerous open sores on her arms, face, and chest area, and Resident #5 had an open sore on her left arm. Record review revealed each residents chart included a document " Health Issues Regarding Kitchen Access ". This document stated that " open sores that are not covered pose a risk and are in violation of existing health regulations. Thus, an individual with untreated, uncovered sores will not have access to the kitchen until s/he treats and covers all sores. "	W 454	W454 All staff retrained on clients entering the kitchen with open sores. All residents with skin picking concerns due to PWS have consents in place to address open sores and the kitchen. The facility manager will review skin picking, open sores and the kitchen with all new hires and quarterly with all Staff. Completion by 9/8/14.	
W 481	Interview with Staff A and B revealed all residents with open sores are to have the sores covered whenever they are going to have access to the kitchen and if they refuse to cover them they would not be allowed in the kitchen at that time. Staff A and B were not aware residents with open sores were preparing food in the kitchen. 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, interview and record review, the facility failed to keep menus of the food served for 3 of 3 sampled residents (Resident #1, 2, and 3) and 2 of 2 expanded sample residents (Resident #4 and 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 and when they were served. Findings include:	W 481	W481 There are currently 30 days' worth of menus on the clip board in the kitchen where they are to be kept. And there is a substitution list in place and being used daily as needed. To ensure there are always 30 days' worth staff add the current menu to the top and remove the last menu from the back of the clip board. The facility manager will train new hires and all staff quarterly to ensure the clip board contains 30 days of menus at all times. The facility manager is responsible with the help of the lead staff to ensure that there are 30 days of menus posted and a substitution list in place. New hires will be trained and current Staff will be given reminders as needed. Completion by 9/8/14.	

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W 481	<p>Continued From page 20</p> <p>All observations, record reviews and interviews were conducted at the facility from 7/12/14 through 7/17/14 unless otherwise stated.</p> <p>Observations revealed some resident meals were not prepared according to the menus. The menu for 07/16/14 revealed fish was to be served, however, chicken was substituted. For snacks on 07/16/14 Triscuits crackers were substituted for graham crackers, due to the facility being out of graham crackers. Food substitutions were not recorded on the menus.</p> <p>Record review revealed no menus were kept on file for the last 30 day period.</p> <p>Interview with Staff A and B revealed they did not know the menus, showing the meals, snacks and any substitutions needed to be kept for any period of time.</p>	W 481		