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

PRINTED: 01/21/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G031	A. BUILDING _____ B. WING _____	R 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN GROUP HOME	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}	INITIAL COMMENTS This report is a result of a credible allegation survey from 12/29/2015 through 12/31/2015 at Brookhaven Group Home. A sample of 2 Clients from a census of 5 were included in the survey. Two Clients were added as Expanded Sample Clients. Failed provider practice was identified. This survey was conducted by: Shana Privett Jim Tarr Olivia St. Claire The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: (360) 725-3215	{W 000}	RECEIVED FEB 01 2016 Residential Care Services ICF/IID Program	
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) completed Individual Program Plans (IPP) for 2 Expanded Sample Clients (Client #3 and Client #4). This failure prevented Clients from having a plan that staff could use to provide training to meet their needs.	{W 104}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ED (X6) DATE 1/25/16

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

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{W 104}	Continued From page 1	{W 104}		
	Findings include: Review on 12/7/15 of a letter of Credible Allegation of Compliance from Camelot Society dated 12/2/15 stated that Brookhaven Group Home had achieved compliance related to findings to the annual recertification survey conducted on 10/6/15 - 10/9/15. The letter was signed by Staff C. Attached to the letter was a detailed plan of correction for each cited standard. 1. Record review on 12/30/15 at 8:42 AM of Client #3 ' s file revealed there was no current IPP. Interview with Staff A on 12/30/15 at 2:52 PM verified that there was no current IPP. 2. Record Review on 12/30/15 at 9:27 AM revealed that Client #4 did not have an IPP. Interview on 12/30/15 at 11:12 AM with Staff A verified that he had not completed the IPP.		**W104** Client #3 & #4 will have a completed IPP in place by 1-21-2016. All Clients will have completed IPP's within 30days of their move in date or within 30 days of the annual IPP date each year after a Client moves in to the facility. The QIDP will now send each updated IPP to the Executive Director upon completion; the director will monitor performance and ensure the system is working which would mean Client IPP's are completed with allotted time frame. The QIDP will be responsible to complete Client IPPs within the 30days. The executive director will ensure this is happening consistently.	1-21-16
{W 159}	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated and provided oversite of all aspects of 2 of 2 Expanded Sample Clients ' (Client #3 and Client #4) treatment at the facility. This failure put Clients at risk of not receiving the treatment they need to become	{W 159}		

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{W 159}	Continued From page 2 more independent and to live in a less restrictive setting. This is a repeat citation from the recertification survey dated 10/9/2015. Findings include: 1. Record review on 12/30/15 at 8:42 AM of Client #3 ' s file revealed there was no current Individual Program Plan (IPP). Interview with Staff A on 12/30/15 at 2:52 PM verified that there was no current IPP for Client #3. See W260. 2. Record Review on 12/30/15 at 9:27 AM revealed that Client #4 did not have an IPP. Interview on 12/30/15 at 11:12 AM with Staff A verified there was no IPP for Client #4. See W226.	{W 159}	**W159** (I think this is about formal objective not being updated) Clients #3 and #4 have in place new formal objectives tailored to help them work toward less restrictive environments and growth as individuals. All other Clients have current Active treatment objective in place as well. The QIDP with oversight from the executive director will ensure Client objectives are updated as often as necessary. The QIDP is responsible to make the corrections. The executive director will ensure that the Client IPP objectives change as needed and are updated as needed. The QIDP will provide the E.D. with supporting documents as needed and after each Client IPP that show changes and / or updated Client objectives.	1-21-16
{W 226}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 2 Expanded Sample Clients (Client #4) had an Individual Program Plan (IPP) completed within 30 days of being admitted to the	{W 226}		

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{W 226}	Continued From page 3 facility. Failure to complete the IPP in a timely manner prevented all staff from knowing what the plan was for Client #4 and delivering consistent services to the Client. This is a repeat citation from the recertification survey dated 10/9/2015. Findings include: Record Review on 12/30/15 at 9:27 AM revealed that Client #4 did not have an IPP. Client #4 was admitted to the facility on [redacted] 2015. Interview on 12/30/15 at 11:12 AM with Staff A verified he had still not completed the IPP for Client #4. Failure to have an IPP completed within 30 days of admission for Client #4 was cited in the recertification survey on 10/9/2015.	{W 226}	**W226** Client #4 will have a completed IPP by 1-21-16. All residents that move in will have a completed IPP within 30 days of moving in. (The new resident's move in date was [redacted] so she will have a completed IPP within 30 days, by Feb 3rd.) The system has changed from the past, the QIDP is required to send completed IPP's to the E.D. for review after each Client IPP. The QIDP and the E.D. will ensure that timelines are met. The QIDP is responsible for making the above corrections. The executive director will ensure this is happening consistently.	1-21-16
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 2 Expanded Sample Clients (Client #3) had a current Individual Program Plan (IPP). Failure to update the IPP prevented the Client from having her current needs assessed and addressed with objectives to assist in increasing her independence.	W 260		

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W 260	Continued From page 4 Findings Include: Record review on 12/30/15 at 8:42 AM of Client #3 ' s file revealed that there was no current IPP. Interview with Staff A on 12/30/15 at 2:52 PM verified he had not completed the IPP for Client #3.	W 260	**W260** The QIDP is aware that every Client must have a completed IPP at least annually; which in this case I think specifically each Clients "Annual Objective List" must be updated annually with the rest of the Clients IPP. The system has been looked at and was found to be in need of an overhaul. Going forward the QIDP will submit Client IPP's to the E.D. with the allotted time frame for review. The E.D. will ensure the QIDP is "doing a good job" or not. The QIDP is responsible to ensure the changes made to the system happen and that Client IPP's are completed within 30 days of either the move in date or the annual IPP meeting date. The executive director will ensure this is happening consistently.	1-21-16