

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

PRINTED: 09/17/2015
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 R-C 09/10/2015
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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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(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
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(W 000) INITIAL COMMENTS (W 000)

This report is the result of Complaint Investigation #3118236 and a follow up to a follow up of complaint investigation #3005620 conducted at Brookhaven Group Home on 9/10/15. Failed provider practice was identified.

The survey was conducted by:
Terry Patton
Shana Privett

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

(W 153) 483.420(d)(2) STAFF TREATMENT OF CLIENTS (W 153)

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to report a missing client to the state agency immediately following the incident. Failure of the facility to report the incident in a timely manner prevented the state agency from knowing what occurred and ensuring clients were safe.

This is a repeat citation from a follow up to the

*Dated 9/29/15
Mailed 9/30/15*

W153

I was out of town at a training when I was informed of this incident, and after doing the math I determined I would be back within the 5 days allotted to finish an investigation so I said I would call the CRU when I get back "as a follow up call after I investigated what happened when I get back to work". At no time did I say for Staff writing the GER (incident report) not to call and report the incident immediately per protocol. In fact the Staff who wrote the GER and failed to call the CRU as soon as possible had been written for failure to call the CRU immediately after a reportable incident 10/2014. There may have been some kind of communication break down and Staff thought I meant to not call and I would but that was never said nor my intention when stating I'd call when I get back.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jammy E. Baluel</i>	TITLE	(X6) DATE <i>9/29/15</i>
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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 153} Continued From page 1
follow up of a complaint investigation on 10/22/14 to 10/23/14.

Findings include:

Review on 9/10/15 of the facility's investigation of #3118236 dated 6/25/15, indicated Client #1 had eloped from a basement door that was propped open for construction purposes on 6/19/15. The Client walked to an AM/PM store 3 blocks away at approximately 1:00 PM. The Sheriff's department was called. The Sheriff's department called the facility and facility staff drove to the store and picked up Client #1, returning him to the facility at 1:30 PM.

Review on 9/10/15 of the Residential Care Services Intake #3118236 revealed the facility reported the incident on 6/24/15, 5 days after the incident.

Interview with Staff B on 9/17/15 at 8:55 AM verified she notified Staff A about the incident via telephone on 6/19/15 and he said he would call CRU. When asked why Staff B didn't notify the state agency, she indicated Staff A said he would make the call.

{W 153} I did call the CRU and report the incident as soon as I got back to work from the training. All Staff were retrained that reportable incidents are to be reported immediately, no exceptions.

We will continue per "Camelot's Annual Training Plan" to have in-services at least twice a year on when to call the CRU, and how, etc.

The facility Manager and the QIDP will be responsible to ensure that Staff know which incidents are reportable to the CRU immediately and that Staff understand if they are to report to the CRU then a call will be made to the CRU ASAP; no exceptions.

9/18/15

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

Red Va/15

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{W 000}	<p>INITIAL COMMENTS</p> <p>This report is a result of a follow up survey conducted on 10/22/14 and 10/23/14 by Kathy Heinz. There was an identified failed facility practice of the ICF/IID regulations. (Reference intake number 3049390)</p> <p>The Survey Team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long Term Care Administration Department of Social and Health Services PO Box 45600 Olympia, WA 98504-5600 Telephone: 360-725-2405 Fax: 360- 725-2642</p>	{W 000}	<p>W153</p> <p>The Staff who failed to report the missing Client to the CRU was written up and then retrained with all Staff on 10/23/2014 via an in-service. The in-service stated that CRU calls for missing person are made as soon as all Clients are safe.</p> <p>Mandatory reporting in-services are done upon hire at the main office and then at least quarterly at each facility and as needed. The Facility Manager has posted in their office the CRU number and what incidents are immediately reported as a kind of cheat sheet for Staff.</p>	10/23/14
{W 153}	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, facility staff failed to notify the facility administrator and the state agency of an incident when they discovered a resident was missing. Failure of the staff to notify the administrator prevented the administrator from knowing what occurred and thus taking immediate action to prevent future occurrences. Failure of the staff to notify the state agency prevented the state</p>	{W 153}	<p>The Facility Manager and / or the QIDP will follow up with a call to the CRU to report findings and conclusions within 5 days of the incident. Basically a facility report will be made for each call to the CRU, to ensure a call has been made, the correct information has been given and our findings / conclusion and or system changes if any.</p> <p>The QIDP with help from the Facility Mgr. will ensure all Staff are trained and aware of their responsibility to report to the CRU (when, why, how, etc...) ASAP.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James A. DeW</i>	TITLE ED	(X6) DATE 12/29/14
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{W 153}	<p>Continued From page 1</p> <p>agency of knowing about the incident in a timely manner . Findings include: Observation on 10/22/14 revealed Resident #1 lived in a home that used alarms to alert staff each time a door or window was opened. Review on 10/22/14 of an incident report written by Staff B (direct care staff) on 10/20/14 at 9:27 PM, revealed Staff B and D (direct care staff) were assisting residents with medications and snacks at approximately 8 PM. "Shortly after all medications and snacks were given, staff went downstairs to do a regular check as usual and staff found out Resident #1 was gone, staff went walking down the street and found Resident #1 coming back with a bag that had goodies in" " She was gone for about 6 mins when staff found out she was gone. Staff had to walk about 15 minutes to catch up with Resident #1." There was no indication from the incident report the state agency was notified. Review of a facility in-service document dated 6/19/14 revealed the trainer was Staff C (house manager) and Staff B was in attendance. The training document read " state agency calls must be made on the same day the incident occurred. You must make a call to the state agency for any of the following reasons : missing client, assault on others ..." Interview with Staff A (Administrator) on 10/22/14 revealed Staff B did not notify the facility manager or the Administrator when they discovered Resident #1 missing. The facility manager became aware of the incident on 10/21/14 (the following day) when he read a note written by Staff B. Staff A immediately notified the Administrator . Neither Staff A,B,C or D had called the state agency to report the incident. The surveyor asked Staff A to make a report to the state</p>	{W 153}		

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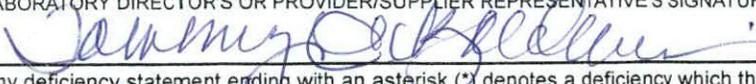
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{W 153}	Continued From page 2 agency on 10/22/14.	{W 153}		

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W 000	<p>INITIAL COMMENTS</p> <p>This report is a result of deficiencies that were found during an investigation (CRU Intake# 3005620) between the dates from 5/29/2014 through 6/20/2014 at Brookhaven Group Home. Violations of ICF/IID regulations were found.</p> <p>The survey was conducted by: Terry Patton, RN, BSN</p> <p>The survey team is from:</p> <p>State of Washington Department of Social and Health Services Residential Care Services Administration ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642</p>	W 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 22 2014</p> <p style="text-align: center;">DOHS-ADSA Residential Care Services ICF/MR Program</p>	
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to report the 5/4/2014 occurrence of 2 of 2 resident to resident assaults by Resident #1 against Resident #2 and against Resident #3 to the Complaint Resolution Unit (CRU). Failure to make Mandatory Reports to government oversight agencies prevents those agencies from</p>	W 153	<p>W153</p> <p>The facility Manager will call the CRU and report this incident ASAP.</p> <p>A system has been put in place where the facility manger will call as a facility reporter for all incident reports that require a report to be sent to the CRU. This will ensure that there will be at least one CRU report made even if as in this case the Staff states they will call and does not.</p>	7/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 ED 8/19/14

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W 153	Continued From page 1 having knowledge of assault incidents, resulting in delayed investigations and placed residents at potential risk of harm. Findings Include: All records reviews and interviews occurred between 5/29/2014 and 6/20/2014. Record review revealed two incidents of assaults which occurred on 5/4/14. On 5/30/2014 and 6/4/2014 Staff 4, the facility manager, gave this investigator General Events Reports (GER) of assaults which occurred on 5/4/2014 between 5:00 PM and 6:00 PM. GERs written by Staff #7 on 5/4/2014 noted that Resident #1 hit Resident #2 on her back several times. Then Resident #1 hit Resident #3 on the back of her head with his fist. A GER, written by Staff #6 dated 5/5/2014, described how Resident #1 became upset on 2014 and assaulted Resident #2. Resident #1 then talked on the telephone briefly. After he talked on the telephone Resident #1 assaulted Resident #3. The GER by Staff #6 noted that the police came and took Resident #1 to Evergreen Hospital for a mental health evaluation because the police believed Resident #1 may have been a danger to himself and others. Resident #1 was evaluated and released from the hospital. He was returned to the facility following the mental health evaluation. Review of Intakes by the Complaint Resolution Unit (CRU) revealed that the facility did not make a report to CRU of the 2014 assaults by Resident #1 against Residents #2 and #3 and the intervention by the police. Interviews with Staff #2, #4, #6, and #7 revealed that no facility staff reported to CRU the 2014 assaults on Residents #2 and #3 by Resident #1 or the police intervention.	W 153	The QIDP will follow up with the facility manager on all incident reports that I review that require a CRU call to be made, I will then document my findings in the GER. If I am not satisfied with the results from my findings I will make an additional call to the CRU or require the facility manager to follow up with another call. Monthly at the mandatory Team meeting we will review all incidents that require a call to the CRU as to what was done right what could have been done better with the thought process of each of us learning and getting better at what we do. Our goal is to prevent the need for a call in the first place. All corrective action will be completed by 8/29/2014 The QIDP will be responsible to ensure the Facility Manager and all Staff are trained as to what is expected of them when it comes to reporting incidents to CRU or not. <u>W154</u> A training on how to properly investigate incidents will be done by the QIDP at the next team meeting on 8/19/2014. The facility manager and the QIDP will investigate all incidents thoroughly with in the allotted 5 days.	8/29/14	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154			

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W-154	<p>Continued-From page 2—</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on records review and interviews, the facility failed to thoroughly investigate 2 of 2 incidents of assaults by Resident #1 on Resident #2 and then on Resident #3. This failure resulted in Resident to Resident assaults not being reported to the Complaint Resolution Unit (CRU). In addition, the facility's failure to investigate these assaults prevented the facility taking corrective actions to prevent further assaults. Findings Include:</p> <p>All records reviews and interviews occurred between 5/29/2014 and 6/20/2014.</p> <p>Record review revealed one General Event Report (GER) written by Staff #6 on [redacted] 2014 and three GERS written by Staff #7 on [redacted] 2014. These GERS reported 2 incidents of assaults between 5:00 PM and 6:00 PM on [redacted] 2014 by Resident #1 on Resident #2 and then on Resident #3. Review of the four GERS did not reveal which staff were working at the facility between 5:00 PM and 6:00 PM on [redacted] 2014.</p> <p>Review of the facility staffing schedule revealed that Staff #6 and Staff #9 were scheduled to work on [redacted] 2014 between 5:00 PM and 6:00 PM, when the assaults occurred. Interview with Staff #6 and Staff #7 revealed they were the only staff working at the facility on [redacted] 2014 between 5:00 PM and 6:00 PM.</p> <p>Review of an e-mail from Staff #1 (Executive</p>	W 154	<p>The QIDP will do a better job than he has been doing when investigating GERS as it is ultimately my responsibility to ensure investigations are through.</p> <p>The Executive Director who reads most of the GERS will give me a heads up when an investigation is lacking in some way or another.</p> <p>The QIDP will ensure that all investigations are through and all calls to the CRU that are required have been done and or followed up by the facility manager.</p>	
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W-154

Continued-From page 3

Director) and interviews with Staff #2 (Qualified Intellectual Disabilities Professional) and Staff #4 (Facility Manager) revealed they were unaware that Staff #6 and Staff #7 were the only staff working at the facility on [REDACTED] 2014 between 5:00 PM and 6:00 PM. A thorough investigation by the facility should have revealed that only two staff were working at the facility during the [REDACTED] 2014 assaults and one of those staff could not help with the assaults because she was committed to keeping Resident #4 in line of sight.

Review of the GERs written by Staff #6 and Staff #7 which were reviewed by Staff #2 (Qualified Intellectual Disabilities Professional) and Staff #4 (Facility Manager) failed to reveal any report of the [REDACTED] 2014 assaults to the Complaint Resolution Unit. Review of the Complaint Resolution Unit intakes revealed the State Agency did not receive any report of the [REDACTED] 2014 assaults by Resident #1 on Resident #2 and then on Resident #3.

Interviews with Staff #2, Staff #4, Staff #6 and Staff #7 revealed that no facility staff called the Complaint Resolution Unit to report the [REDACTED] 2014 assaults by Resident #1 Resident #2 and then on Resident #3. A thorough investigation by the facility should have found the facility's failure to report the assaults to CRU.

Review of the GERs written by Staff #6 and Staff #7 and reviewed by Staff #2 (Qualified Intellectual Disabilities Professional) and Staff #4 (Facility Manager) failed to reveal any corrective action to prevent re-occurrence of assaults. Review of the GER written by Staff #6 on 5/5/2014 revealed Staff #4 reviewed the GER on 5/13/2014. Staff #4 failed to determine that the [REDACTED] 2014 assaults were not referred to CRU and did not implement

W 154

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~~W-154~~ Continued-From page 4
any corrective action that would assure reports were made to CRU in the future. Staff #4 failed to identify and implement corrective actions pertinent to the staffing and the need for one staff to close monitor Resident #4. One of the two staff had to stay with Resident #4 as required by Resident #4 ' s Positive Behavior Support Plan. Only one staff was available to attempt to prevent the assaults. The failure to identify corrective actions to protect Residents from future assaults should have been revealed if the facility ' s investigation had been thorough.

W 186 483.430(d)(1-2) DIRECT CARE STAFF

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

This STANDARD is not met as evidenced by:
Based on record review and interviews, the facility failed to assure sufficient staff were present to provide Line of Sight staffing as required by the Positive Behavior Support Plan (PBSP) for Resident #4 and to assure no residents would be harmed if a resident became assaultive. This staffing failure resulted in Resident #2 and then Resident #3 being assaulted by Resident #1. Findings Include:

All records reviews and interviews occurred between 5/29/2014 and 6/20/2014.

Review of Resident #4 ' s Positive Behavior

W-154

W 186

W186

Note: All Staff are required to take Right Response training before they are allowed to work unsupervised which is positive behavioral support with optional skills which are utilized when physical holds are required; the therapeutic holds are only used when all else has failed to keep everyone safe. Staff are trained to respond to all known antecedents to behaviors that are potentially harmful to Clients (ex. Yelling / arguing usually ends in an assault if Staff do not intervene quickly helping the Clients resolve their particular disagreement or stepping in between putting themselves in harm's way to ensure an assault does not occur keeping all Clients safe from harm.

We have hired 3 new Staff at Brookhaven and 1 starts Monday the 21st 2014. We will continue to aggressively hire until we are fully Staffed.

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

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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 C 06/20/2014
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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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(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
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W 186	<p>Continued From page 5</p> <p>Support Plan dated September 13, 2013, revealed that Resident #4 is an elopement risk and has Prader-Willi Syndrome. Staff are to visually monitor Resident #4 at all times without exception. If Resident #4 is in the bathroom or her bedroom she may have privacy, however, staff are to check her bedroom at least hourly. Interviews determined only Staff #6 and Staff #7 were working between 5:00 PM and 6:00 PM on [REDACTED] 2014 when Resident #1 assaulted Resident #2 and then assaulted Resident #3. Interviews with Staff #6 and #7 revealed that Staff #6 kept Resident #4 in Line of Sight per Resident #4 's PBSP on [REDACTED] 2014 when Resident #1 assaulted Resident #2 and then assaulted Resident #3. Staff #6 was unable to assist Staff #7, who had unsuccessfully attempted to prevent Resident #1 from assaulting Resident #2 and then assaulting Resident #3. Staff #2, the facility Qualified Intellectual Disabilities Administrator, stated that 2 staff on duty were enough for the facility to assure Resident #4 had Line of Sight monitor as required in her PBSP and to protect the other residents. Staff #3, #4, #5, #6, and #7 all stated that two staff were not sufficient to assure Resident #4 was safe and to prevent Resident #1 from assaulting Residents #2 and #3 as had occurred on [REDACTED] 2014.</p>	W 186	<p>One Staff trained on site (Completing the Staff checklist) and one who has passed Right Response as well as the other trainings required is more than capable of handling one resident who has become assaultive. Even with the other Staff who is monitoring Resident #4 in line of site. If additional assistance is needed Staff are to utilize Bedford Staff next door; until either the facility manager arrives to assist or if a Staff is on an outing returns to the facility.</p> <p>The facility will ensure that all Staff are properly trained as stated above and ready for the rigors of the job. The QDIP will create a document that addresses whether or not a Staff is ready for demands of the working environment at Brookhaven Group Home; the Staff, facility manager and the QIDP will sign stating that this Staff is ready and competent to handle whatever comes their way in terms of behaviors / emergency's etc. Staff not deemed capable will either be let go or asked to consider transferring to a facility where their short comings will not hinder their ability to do the job due to the change to a facility with different clientele.</p> <p>The QIDP will ensure that there are enough capable Staff on duty to ensure all Clients are safe from harm.</p>	8/29/14
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