



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600, Olympia, WA 98504-5600

Statement of Deficiencies/
Plan of Correction
Page 1 of 3

License #675
Camelot Group Home

Completion Date:
4/29/15

You are required to be in compliance at all times with all laws and regulations to maintain your assisted living facility license.

The department has completed data collection for the unannounced on-site inspection on 4/14/15 to 4/17/15 of :

Camelot Group Home
9201 2nd Ave., NW
Seattle, WA 98117

The following sample was selected for review during the unannounced on-site visit: 4 of 4 current clients.

The department staff that inspected/investigated the assisted living facility:

Gerald Heiling, Kathy Heinz, Jim Tarr

From:

DSHS, Aging and Disability Services Administration
Residential Care Services, ICF/IID
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.

Leila Baniz
Residential Care Services

04/30/15
Date

I understand that to maintain an assisted living facility license I must be in compliance with all of the laws and regulations at all times.

Samuel [Signature]
Administrator (or Representative)

11/6/15
Date

WAC 388-78A-2650

Reporting fires and incidents.

The assisted living facility must immediately report to the department's aging and disability services administration:

- (1) Any accidental or unintended fire, or any deliberately set but improper fire, such as arson, in the assisted living facility;

Based on record review and interview the facility failed to report an accidental fire to the State agency. Failure to report to the State Agency prevented the State agency from determining if the agency took appropriate actions.

Findings include:

Interview with staff D on 4/17/15 about the facility's fire evacuation drills revealed the facility had had a fire recently.

Record review of the incident report dated 3/1/15 revealed staff was preparing dinner in the kitchen and then a frying pan began to smoke and then briefly burst into flame. It was doused quickly, but the smoke caused the fire alarm to ring." Residents were evacuated and the fire department responded. The fire department determined the house was safe. The facility determined the cause may have been "burned food on the burner or on the bottom of the pan."

Interview with the QIDP on 4/17/15 revealed the facility did not report the incident to the State agency.

WAC 388-78A-24642

Background checks—National fingerprint background check.

- (1) Administrators and all caregivers who are hired after January 7, 2012 and are not disqualified by the Washington state name and date of birth background check, must complete a national fingerprint background check and follow department procedures.

Based on observation, record review and interview the facility failed to

ensure a staff working with Residents had completed a national fingerprint criminal background check. Failure of the facility to ensure staff have completed the national fingerprint portion of the criminal background check placed Residents at risk when an unqualified staff worked with them.

Findings include:

Observation on 4/16/15 revealed Staff E was working with Residents in the facility.

Staff E worked one day in January, twelve days in March and three days in April with Residents.

Record review on 4/16/15 revealed Staff E was hired on 1/11/15 and had completed a State of Washington criminal background check. The State of Washington criminal background check was completed 1/7/15. Staff E had not completed a national background check that included a fingerprint check.

Interview with the QIDP on 4/16/15 revealed Staff E worked in another part of the agency that did not require staff to complete a national fingerprint check.

Plan of Correction:

Date Completed:

Reporting fires to the CRU was added to the ISC training checklist and the fire training on 6/9. The issue of having staff from our Supported Living program (who are not required to get national fingerprint checks) work at group homes was discussed at our April supervisory meeting, and the ED stated that Support Living staff can only work in group homes if they meet the group home standard.

The ISC training checklist and fire training will ensure that we maintain compliance. Also, ISC know to contact supervisors in the event of emergencies, and now supervisors have clarity on the expectations of when to call CRU. Each employee's certifications are kept on file at the main office, and the office manager discusses with SL staff that if they want to work at group homes, they need to get fingerprints. If they do this, she will have a record and then let managers at group homes know.

Supervisors will instruct staff to call CRU in case of fires, and supervisors will ensure that SL staff have gotten fingerprints before working in a group home.



The Camelot Society

6912-220th St SW, Suite 301
Mountlake Terrace, WA 98043

Phone: 425-771-2108
Fax: 425-771-2126

July 2, 2015

Gerald Heilinger, Field Manager
State of Washington/Department of Social & Health Services
ADSA, RCS, ICF/IID Survey and Certification Program
PO Box 45600
Olympia, WA 98504-5600

RE: Credible Allegation of Compliance – Camelot Group Home
Complaint Investigation 3075591 and Annual Recertification Survey 4/14/15-4/17/15
Condition of Participation: Governing Body & Active Treatment Services

Dear Mr. Heilinger:

This letter is to inform you that the Camelot Society, specifically Camelot Group Home, is verifying that we have achieved compliance related to the findings made as the result of the above referenced Complaint Investigation & Annual Recertification Survey.

The Camelot Society's Camelot Group Home is ready to demonstrate compliance related to the Conditions of Participation outlined in the summary report dated April 30, 2015. Please refer to the individual tags for the corrective actions taken, including systems changes and compliance monitoring.

If you have any questions, please contact me at the (425) 771-2108 or by email at tammy@camelotsociety.org.

Sincerely,

Tammy E. Baldwin
Executive Director
Camelot Society – Camelot Group Home

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Residential Care Services
ICF/IID Program

Camelot Society – Camelot Group Home

Credible Allegation of Compliance – June 10, 2015

W102 – 42 CFR 483.410 Governing Body

Specifically the following corrections were made:

W104 – CFR 483.410 (a) (1): Exercise general operating direction over the facility

1. How and when the corrections were made: The dining room floor was sanded and a clear coat of sealant was put on the area where the wood was splintering on 4/23 by the maintenance supervisor. The floor was getting scratched from the metal bottoms of the old dining room chairs, so replacement chairs were bought on 5/27, along with felt pads to put on the chairs to protect the floors. The door from the kitchen to the back of the house was fixed on 4/23 and no longer has a crack in it. The living room carpet was discussed at a staff meeting on 4/27 and a deep cleaning occurred on 4/28. The light bulbs in the bathroom were replaced on 4/16. The outside siding on the back of the house was fixed on 6/17 with replacement pieces put up. The blackberry bushes were removed from the back yard on 4/23. The inside of kitchen drawers received a deep cleaning on 4/23 and protective covers were put into high-use drawers on 5/26. The drywall of the corner in the kitchen was fixed on 5/29 and was painted on 6/2. An exterminator came out on 5/6 and took care of the ant problem. The corner of the nook in the dining room was re-spackled on 5/29 and painted on 6/2.
2. The systems that are in place to maintain compliance: It is on the list of manager duties to do a weekly walk through of the facility, and report any issues via work order to get fixed. The exterminator will be coming out bi-monthly to prevent the ant issue from recurring. At biweekly staff meetings the manager asks all ISC if there are any issues with the house, and sends in a work order for any issues discussed. The QIDP will do a walk through if manager is gone.
3. How the corrective action will be monitored to ensure the deficient practice does not recur: The facility manager will do a weekly walk through the house and report anything that needs to be fixed to the main office by sending in a work order. The QIDP will review work orders for completion no less than monthly.

W108 – CFR 483.410 (b) Compliance with Federal, State, and Local Laws

1. Reporting fires to CRU was added to the ISC training checklist and the fire training document on 6/9. The issue of having staff from our Supported Living program (who are not required to get national fingerprint checks) work at group homes was discussed at our April supervisory meeting, and the ED stated that Support Living staff can only work in group homes if they meet the group home standard.
2. The ISC training checklist and fire training will ensure that we maintain compliance. Also, ISC's know to contact supervisors in the event of emergencies, and now supervisors have clarity on the expectations of when to call CRU. Each employee's certifications are kept on file at the main office, and the office manager discusses with SL staff that if they want to work at group homes, they need to get fingerprints. If they do this, she will have a record and then let managers at group homes know. The manager is responsible for asking the staff's supervisor or the office manager.
3. Supervisors will instruct staff to call CRU in case of fires, and supervisors will ensure that SL staff has gotten fingerprints before working in a group home. All new employees (SL or group home) will get fingerprints as discussed in our April Supervisory meeting.

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Residential Care Services
ICF/IID Program

W125 – CFR 483.420 (a) (3) Protection of client's rights

1. Consents for the alarms on the main entrances to the home were obtained by all four guardians. A consent for the alarm on resident #2's window was signed by her guardian on 5/3/15. Money management programs were created for each client on 5/6 and money is now unlocked. Resident #3 has a key program as of 6/10 that will assist him in learning to independently open his door.
2. Consents were signed and reviewed at a Human Rights Committee meeting on 6/4. The money programs are listed in each client's objective list, and also posted in the money cabinet to ensure understanding and compliance. Resident #3's key program is a formal program on his objective list. Staff report to manager or QIDP if there are any difficulties or regression with programs.
3. The Human Rights Committee meets monthly to discuss consents and determine if restrictive procedures are still necessary. All consents are discussed at least annually with guardians. The QIDP reviews all consents and programs at least bi-annually, or as needed.

W154 – CFR 483.420 (d) (3): Staff treatment of clients

1. A document regarding [REDACTED] elopement was created on 6/9 for staff to fill out if/when he elopes. All PBSPs are reviewed at staff meetings when updates are made, and new staff read them as part of orientation.
2. Staff have started signing on the back of PBSPs to prove training and understanding.
3. When elopements do occur, the manager and/or QIDP will ensure that all proper documentation is filled out, and that if further investigation is required, that it occurs.

W195 – 42 CFR 483.440 Active Treatment Services

Specifically the following corrections were made:

W196 – CFR 483.440 (a) (1): each client receives active treatment

1. Specific details about how to guide Resident #3 was added to his objective list on 6/10. The method in which staff guides Resident #3 was discussed with a consultant from the Deaf Blind Service Center on 5/14. The program for Resident #3 where staff sign "sit" before he sits remains in his objective list, and it is highlighted so it is obvious to staff. The program where staff sign "bathroom" before guiding Resident #3 to the bathroom remains in his plan, and is highlighted. A specific training section was created on 6/10 in his program binder that illustrates how staff should be signing to him.
2. When staff are being trained, they will refer to the training section of Resident #3's program binder to learn how to appropriately guide, sign, and run programs with him. These will be reviewed periodically at staff meetings to ensure staff's knowledge of sign.
3. The QIDP reviews how programs are going at least twice a year and the manager monitors staff to ensure they are running programs correctly.

W206 – CFR 483.440 (c) (1): each client must have an individual plan

1. Resident #3 met with a case manager from the Deaf Blind Service Center on 5/14, where his knowledge of sign was assessed, and plans for increased independence were discussed. Her input was used in updating his IPP on 5/21.
2. The case manager came out to Camelot on 6/1 to assess his environment and give further consultation. She will be met with as needed and is assisting the QIDP in finding more resources for Resident #3.
3. The case manager is included now in his CFA, and a consent for release of information to the DBSC was signed by Resident #3's guardian. They will continue to be a resource for Camelot.

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Residential Care Services
ICF/IID Program

W240 – CFR 483.440 (c) (6) (i): individual program plan must describe relevant interventions

1. Resident #3 met with a case manager from the Deaf Blind Service Center on 5/14, where his knowledge of sign was assessed, and plans for increased independence were discussed. Her input was used in updating his IPP on 5/21. She confirmed that the way he has been guided is appropriate and she gave us tips on how to best meet his communication needs.
2. The case manager came out to Camelot on 6/1 to assess his environment and give further consultation. She will be met with as needed, possibly monthly, and is assisting the QIDP in finding more resources for Resident #3.
3. The case manager is included now in his CFA, and a consent for release of information to the DBSC was signed by Resident #3's guardian. They will continue to be a resource for Camelot.

W247 – 483.440 (c) (6) (iv): The individual program plan must include opportunities for choice and self-management

1. We had an active treatment in-service at our staff meeting on 4/13, active treatment was discussed again at a staff meeting on 4/27, and we went through a more in depth PowerPoint on active treatment on 6/1. All medications that were able to be untimed, as determined by medical professionals, were untimed. Only one resident has a timed morning medication now, and this time was switched from 7am to 8am, so that he has more control over his morning routine and can sleep in if he chooses. The other three clients can sleep until they choose before starting their morning routine.
2. QIDP, Manager, and Lead ISC are all aware of the need to promote increased independence for our clients, and are monitoring staff to ensure they are engaging clients in this as much as possible. The Physician's Orders were all updated for this quarter reflecting the medications that can be untimed, and the MARs were updated accordingly.
3. Each resident has specific programs to gain more skills/independence in their daily lives with are reviewed at least twice a year. In addition to how involved clients are in their programs, QIDP will also check in with staff and clients about how involved they are in other activities of daily life at their annual IPP meetings. The agency nurse is aware of the changes in medication times, and is a great help and consultant in determining when medications should be given. When new medications are prescribed in the future, we will explore what time makes the most sense and if that specific medication can be untimed.

W249 – CFR 483.440 (d) (1) implementation of the program for continuous active treatment

1. The programs involving "sit" and "bathroom" remain in Resident #3's objective list, they are highlighted, and a specific staff training section was added to his binder to assist staff in signing. The case manager from DBSC consulted with the QIDP and recommended we add a communication box into Resident #3's objective list, and this was done on 6/9.
2. With the new training section in the program book, staff have the available tools to implement the programs consistently, and they understand the importance of assisting clients in completing their programs to gain new skills.
3. QIDP will monitor the programs at least twice annually, and QIDP and/or manager will check in with staff to see how the programs are going and to make sure they are being implemented correctly. If there are any difficulties or regression, ISC are to report to manager/QIDP.

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Residential Care Services
ICF/IID Program

W250 – 483.440 (d) (2): program implementation: active treatment schedule

1. Active treatment schedules were created and put in place on 4/28.
2. The active treatment schedules are kept in each client's program binder, so they are accessible to staff at all times.
3. The active treatment schedules will be reviewed at least twice annually during each client's review date by the QIDP. They will be updated more frequently if there are any life changes and at staff meetings.

W259 – CFR 483.440 (f) (2) comprehensive functional assessments reviewed annually or as needed

1. Resident #3 met with a case manager from the Deaf Blind Service Center on 5/14, where his knowledge of sign was assessed, and plans for increased independence were discussed. Her input was used in updating his IPP on 5/21.
2. The case manager came out to Camelot on 6/1 to assess his environment and give further consultation. She will be met with as needed, possibly monthly, and is assisting the QIDP in finding more resources for Resident #3.
3. The case manager is included now in his CFA, and a consent for release of information to the DBSC was signed by Resident #3's guardian. They will continue to be a resource for Camelot.

WAC 388-78A-2650 Reporting fires and incidents.

1. Reporting fires to CRU was added to the ISC training checklist and the fire training on 6/9.
2. The ISC training checklist and fire training will ensure that we maintain compliance. Also, ISC know to contact supervisors in the event of emergencies, and now supervisors have clarity on the expectations of when to call CRU.
3. Supervisors will instruct staff to call CRU in case of fires.

WAC 388-78A-24642 Background checks – national fingerprint background check

1. The issue of having staff from our Supported Living program (who are not required to get national fingerprint checks) work at group homes was discussed at our April supervisory meeting, and the ED stated that Support Living staff can only work in group homes if they meet the group home standard.
2. Each employee's certifications are kept on file at the main office, and the office manager discusses with SL staff that if they want to work at group homes, they need to get fingerprints. If they do this, she will have a record and then let managers at group homes know. Managers will ask staff or staff supervisor and get a copy from the office manager. All new staff will be getting them.
3. Supervisors will ensure that SL staff has gotten fingerprints before working in a group home.

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Residential Care Services
ICF/IID Program

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2015
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NAME OF PROVIDER OR SUPPLIER CAMELOT GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 9201 2ND AVENUE NORTHWEST SEATTLE, WA 98117
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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	<p>INITIAL COMMENTS</p> <p>This report is a result of an Annual Recertification Survey and a complaint investigation (3075591) conducted at Camelot Group Home from 4/14/15 through 4/17/15. The sample included two sample Residents and two expanded sample Residents.</p> <p>The survey was conducted by: Gerald Heilinger Kathy Heinz Jim Tarr</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		
W 100	<p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS</p> <p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active</p>	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 100	Continued From page 1 treatment as specified in §483.440.	W 100			
W 102	<p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation of Active Treatment Services. Findings Include: The facility did not meet the Condition of Participation (COP) of Active Treatment Services. The facility did not ensure one Resident received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports. See W195.</p> <p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition of Participation in Governing Body and Management by not exercising operating direction over the facility and by not meeting the requirements for the Conditions of Participation of Active Treatment Services. This failure potentially affected all Residents served.</p> <p>Findings Include:</p> <p>1. The governing body failed to exercise general</p>	W 102			

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W 102	Continued From page 2 direction in a manner which ensured the facility was being maintained. See W104.	W 102		
W 104	<p>2. The facility did not meet the Condition of Participation in Active Treatment Services by: A. not developing training plans to address assessed needs; B. not implementing training objectives; C. not ensuring the Interdisciplinary Team contained the correct professional; D. not providing directions to staff on how to train Residents, and E. not encouraging Residents to manage their daily activities. See W195.</p> <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 observations and interviews, the facility failed to ensure the home was kept in good repair. Observations of the home revealed numerous items in need of repair and cleaning. This failure prevented Residents from living in a clean, sanitary home free of potential hazards.</p> <p>Findings include: Observations on 4/14/15 during a general tour of the home revealed the following things in need of repair or cleaning: the dining room floor was badly scratched and marred with one area where the wood flooring was splintering; the door from the kitchen to the back of the house had a crack in it; the living room rug was dirty and stained; the bathroom light fixture over the sink had one light bulb missing and a second one was burned out; the outside siding on the back of the house</p>	W 104		

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W 104	Continued From page 3 appeared to have dry rot; there were blackberry bushes growing in the back yard; The inside of multiple drawers in the kitchen presented with food spills and grime. The corner of one wall in the kitchen presented with missing paint and the drywall was gouged. There were ants in the kitchen trailing around the counter. The corner of a nook in the dining area was missing paint and the spackle was gouged.	W 104		
W 108	483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to comply with State laws WAC 388-78A-24642 (1) and WAC 388-78A-2650 (1) when they failed to report a fire and ensure a staff working with Residents had completed a national fingerprint criminal background check. Failure of the facility to ensure staff have completed the national fingerprint portion of the criminal background check placed Residents at risk when an unqualified staff	W 108		

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W 108	Continued From page 4 worked with them. Failure to report the fire to the State agency prevented the State agency from determining if the facility took appropriate corrective action when the fire occurred. Findings Included: See attached citations under WAC 388-78A-24642 (1) and WAC 388-78A-2650 (1). Criminal Background Checks Observation on 4/16/15 revealed Staff E was working with Residents in the facility.	W 108		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to protect the rights of all four Residents when the facility put monitoring alarms on all exterior doors, locked up their personal money and locked a Resident ' s bedroom door (Resident #3). These failures resulted in abridgements to resident ' s rights without due process. Findings include: 1. Observation throughout the survey between	W 125		

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W 125	<p>Continued From page 5</p> <p>4/14/15 and 4/17/15 revealed all exterior doors were alarmed and sounded loudly when Residents entered or exited the home.</p> <p>Record review on 4/16/15 for Resident #1, #2 and #3 revealed there were no documents abridging their rights to come and go freely from their own home without staff awareness.</p> <p>Interview with the Qualified Intellectual Disability Professional (QIDP) verified there were no abridgments of the residents' rights to come and go freely from their own home. She stated the alarms have been in place as long as she has worked at the facility.</p> <p>2. Interview with QIDP on 4/14/15 regarding restrictions in the Residents' home revealed that Resident # 2's bedroom window had an alarm on it because Resident #1 had eloped out of her window in the past. The QIDP confirmed that there was no abridgement of Resident # 2's rights for the window alarm.</p> <p>3. Observation on 4/14/15 revealed all of the residents' money was located in a locked cupboard in the kitchen area. Residents did not have keys to open the locked cabinet.</p> <p>Observation on 4/15/15 at 11:57AM at the Ballard Senior Center found Resident #2 arriving for lunch with Staff F. Resident #2 sat at a table in the dining room with Resident #1 and Resident # 4. Staff F was observed with Resident #2's money pouch paying for Resident # 2's lunch at the cash register. Staff F maintained possession of Resident #2's money pouch throughout the meal.</p>	W 125		

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W 125	<p>Continued From page 6</p> <p>Observation on 4/15/15 at 1:59PM at the Mighty O Donut Shop revealed that Staff F paid for Resident # 2 ' s donut with a gift card that Resident # 2 had received earlier. Staff F maintained possession of the gift card.</p> <p>Record review on 4/16/15 of Resident # 2 ' s 10/31/14 Functional Behavioral Assessment indicated in the section Math/Money Skills that Resident # 2 " carries her own money when out in the community " .</p> <p>Record review on 4/16/15 revealed there were no documents abridging the rights of all Residents to have free access to their money.</p> <p>4. Observation during a tour of the home on 4/14/15 of Expanded Sample Resident #3 ' s revealed his bedroom door was locked.</p> <p>Interview with Staff F revealed Resident #3's bedroom was locked to keep out other Residents and that Resident # 3 was not able to open his door independently.</p> <p>Review of Resident #3 ' s record on 4/16/15 revealed there was no abridgement of Resident #3 ' s rights related to his bedroom being locked.</p>	W 125		
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</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 record review and interview the facility failed to investigate and document investigative findings when a resident left his home and staff</p>	W 154		

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W 154	<p>Continued From page 7</p> <p>could not locate him. This failure prevented the facility from knowing what happened and taking appropriate corrective action.</p> <p>Findings include:</p> <p>Review of a facility "Behavior Data" sheet on 4/16/15 revealed under the section titled "comments/details": "Resident #1 eloped from home came back with wire garden item and garbage" on 3/30/15.</p> <p>The state surveyor asked the Qualified Intellectual Disability Professional (QIDP) for the investigation of the incident. The QIDP produced a "T log" (electronic note) dated 3/30/15. The T log revealed "after snack about 2:40 PM Resident 1 eloped from his home for about five minutes. Staff was out looking for the resident. Upon return he had garden wire and a bag of garbage. Resident #1 washed his hands after disposing of the garbage. Behavior was logged in his behavior chart."</p> <p>Review of the Positive Behavior Support Plan (PBSP) for Resident #1 dated 1/30/15 revealed he has a history of elopement. Under the section titled "prevention strategies" it revealed "staff to monitor his whereabouts as much as possible by keeping the door chimes on and checking on him periodically."</p> <p>Interview with the QIDP on 4/16/15 revealed she was in the home when the incident occurred. She stated she thought Resident #1 left through the sliding door on the patio and that he was "testing" the new staff.</p> <p>There was no indication the facility determined if</p>	W 154			

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W 154	Continued From page 8 staff working the day of the incident had checked on Resident #1 as described in his PBSP, if the door alarms were working properly or if staff working the day of the incident had been trained regarding the supervision guidelines for Resident #1. There was no indication the PBSP was reviewed to determine if it was adequate.	W 154			
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one Expanded Sample Resident (Resident #3) received a consistently implemented plan based on his observed needs, and that all Residents were encouraged to self-manage their daily routines. The lack of a consistently implemented plan and Residents not being encouraged to manage their daily routines resulted in the Condition of Participation of Active Treatment Services to be not met.	W 195			
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for	W 196			

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W 196	<p>Continued From page 9</p> <p>the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one Expanded Sample Resident (Resident #3) had an interdisciplinary team which included a professional with expertise related to his [REDACTED] deficits, a consistently implemented plan to ensure Resident #3 increased his independent living skills, and a plan that contained instructions to direct care staff on how they were to interact with and train Resident #3. These failures prevented Resident #3 from having the opportunity to acquire skills to increase his independence.</p> <p>Findings include:</p> <p>Record review on 4/16/15 for Resident #3 revealed he had a [REDACTED] His Individual Program Plan (IPP), dated 5/28/14, had instructions for staff to sign "sit" when having him sit down and to sign "bathroom" when using the bathroom. The IPP did not contain instructions on how staff were to help Resident #3 walk from place to place in the home.</p> <p>1. The following observations related to the different methods the staff used to assist Resident #3 to walk:</p> <p>a. Observation on 4/14/15 at 2:43 PM revealed a direct care staff brought him home from work.</p>	W 196		
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W 196	<p>Continued From page 10</p> <p>Resident #3 walked directly behind the staff with Resident #3 having one hand on each of the staff ' s shoulders.</p> <p>b. Observation on 4/14/15 at 2:58 PM revealed Staff A walked Resident #3 from the dining room table to the kitchen with the same technique of both hands on the staff ' s shoulders.</p> <p>c. Observation on 4/14/15 at 4:00 PM revealed Staff A walked with Resident #3 with the same technique of both hands on the staff ' s shoulders.</p> <p>d. Observation on 4/14/15 at 4:15 PM revealed Staff B walked with Resident #3 to the kitchen, but he had Resident #3 holding on to his upper right arm.</p> <p>e. Observation on 4/14/15 at 5:19 PM revealed Staff B walked with Resident #3 having Resident #3 hold onto the staff ' s upper arm.</p> <p>f. Observation on 4/15/15 at 8:45 AM revealed Staff A walked with Resident #3 by having Resident #3 put one hand on her shoulder and Resident #3 ' s other hand on the staff ' s upper arm.</p> <p>g. Observation on 4/15/14 at 9:50 AM revealed Resident #3 was seated at the dining room table stringing beads onto pipe cleaners. Staff A had Resident #3 stand up to go to the bathroom. She had Resident #3 place one hand on her shoulder and Resident #3 ' s other hand on her upper arm. At the start of the hallway leading from the dining room, Staff A put Resident #3 ' s hand on the top of the wainscoting and he then walked independently to the bathroom.</p>	W 196		
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W 196	<p>Continued From page 11</p> <p>h. Observation on 4/15/15 at 11:58 AM revealed Staff C walked with Resident #3 from the living room to the kitchen by having Resident #3 walk with one hand on Staff C ' s shoulder.</p> <p>i. Observation on 4/15/15, at approximately 2:20 PM at a Senior Center in the community where Resident #3 was involved in a knitting class, revealed Staff A walked with Resident #3 to the bathroom by having Resident #3 hold onto Staff A ' s shoulder and upper arm.</p> <p>j. Observation on 4/15/15 at 4:17 PM revealed Staff B walked with Resident #3 by having him hold onto Staff B ' s upper arm.</p> <p>k. Observation on 4/16/15 at 9:17 AM revealed Staff E walked with Resident #3 to the bathroom by having Resident #3 place one hand on each of Staff E ' s shoulders. Staff A instructed Staff E to change the technique to one hand on Staff E ' s shoulder and the other on Staff E ' s upper arm, per instruction from the Qualified Intellectual Disability Professional (QIDP).</p> <p>l. Observation on 4/16/15 at 1:46 PM revealed Staff F walked with Resident #3 and Resident #3 had one hand on each of Staff F ' s shoulders. At 1:49 PM Staff F was observed walking with Resident #3 where he had Resident #3 with one hand on Staff F ' s shoulder and Resident #3 ' s other hand on Staff F ' s upper arm. At 1:55 PM, Staff F walked with Resident #3 again with Resident #3 having one hand on Staff F ' s shoulder and Resident #3 ' s other hand on Staff F ' s upper arm.</p> <p>Interview on 4/15/15 at 9:10 AM with Staff A revealed the technique for having Resident #3 put</p>	W 196		

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W 196	<p>Continued From page 12</p> <p>his hands on both of the staff ' s shoulders or one of the staff ' s shoulders is done for Resident #3 ' s safety and stability.</p> <p>Interview on 4/15/15 at approximately 4:17 PM with Staff B revealed he had Resident #3 walk with Resident #3 ' s hand on his upper arm because he discovered the technique of having Resident #3 put his hands on Staff B ' s shoulders was putting weight on Staff B ' s back.</p> <p>Interview on 4/16/15 at 2:20 PM with the QIDP and Staff D, with Resident #3 ' s record available, revealed the walking technique with Resident #3 where staff have him put a hand on each of their shoulders is the historical way walking with him has been done. They verified there were no instructions in the IPP on how staff should walk with Resident #3.</p> <p>2. The following observations related to how staff communicated to Resident #3 to sit down:</p> <p>a. Observation on 4/14/15 at 2:43 PM revealed a staff directed Resident #3 to a chair but did not sign " sit " to him.</p> <p>b. Observation on 4/14/15 at 4:00 PM revealed Staff A hand Resident #3 sit in an easy chair in the living room area, but did not sign " sit " prior to having him sit down.</p> <p>c. Observation on 4/14/15 at 4:15 PM revealed Staff B did not sign " sit " to Resident #3 before having him sit down.</p> <p>d. Observation on 4/14/15 at approximately 5:40 PM revealed Staff B did not sign " sit " to Resident #3 when seating him at the dining room</p>	W 196		
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W 196	<p>Continued From page 13 table.</p> <p>e. Observation on 4/15/15 at 8:45 AM revealed Staff A did not sign " sit " to him when she seated him at the dining room table.</p> <p>f. Observation on 4/15/15 at 1:06 PM revealed Staff B did not sign " sit " before having Resident #3 sit down.</p> <p>g. Observation on 4/16/15 at 10:54 AM revealed Staff E did not sign " sit " to Resident #3 before having him sit in a chair.</p> <p>h. Observation on 4/16/15 at 1:25 pm revealed Staff A took Resident #3 to an easy chair, had him feel the chair and then he sat down. She did not sign " sit " before having Resident #3 sit down.</p> <p>Interview on 4/16/15 with Staff A at 1:12 PM revealed staff don ' t normally sign " sit " with Resident #3. She said they just have Resident #3 feel the chair.</p> <p>Interview on 4/16/15 at 2:20 PM with the QIDP and Staff D, with Resident #3 ' s record available, verified the IPP contained instructions for staff to sign " sit " with Resident #3 prior to having him sit down.</p> <p>3. The following observations related to how staff assisted Resident #3 to use the bathroom:</p> <p>a. Observation on 4/15/14 at 9:50 AM revealed Resident #3 was seated at the dining room table stringing beads onto pipe cleaners. Staff A had Resident #3 stand up to go to the bathroom. She did not sign " bathroom " to him.</p>	W 196		

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W 196	Continued From page 14 b. Observation on 4/16/15 at 9:17 AM revealed Staff E approached Resident #3 and spoke to him in soft tones about the need to go to the bathroom. Staff E did not sign " bathroom " to Resident #3. Interview on 4/16/15 at 10:23 AM revealed Staff E did not know the sign for " bathroom " . He revealed he normally works at a different home. Interview on 4/16/15 at 2:20 PM with the QIDP and Staff D, with Resident #3 ' s record available, verified the IPP contained a program for staff to sign " bathroom " with Resident #3 when having him go to the bathroom.	W 196			
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that one Expanded Sample Resident ' s (Resident #3) Interdisciplinary Team (IDT) included an expert in training persons with visual and hearing deficits. This failure prevented Resident #3 from receiving training that was approved, directed and overseen by someone knowledgeable in currently	W 206			

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W 206	<p>Continued From page 15</p> <p>accepted training techniques for the visually and hearing impaired.</p> <p>Findings include:</p> <p>See W196 for details of observations.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff walking with Resident #3 both in his home and out in the community. Staff used 3 different techniques: 1. Resident #3 placing one hand on each of the staff 's shoulders and walking directly behind them; 2. Resident #3 placing one hand on a staff 's shoulder and his other hand on their upper arm and walking to the staff 's side; 3. Resident #3 placing his hand on the staff 's upper arm and walking to the side of the staff.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff working with Resident #3 and having him sit in a chair after walking with the staff. On no occasion did the staff sign " sit " with him prior to having him sit down.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff working with Resident #3 and staff were observed verbally interacting with him and giving him verbal directions. Staff did not accompany these verbal interactions with any other means of communication related to Resident #3 ' s hearing deficit.</p> <p>Review on 4/16/15 of Resident #3 ' s Individual Program Plan (IPP), dated 5/28/14, revealed he is [REDACTED]. Review of the list of staff contributing to the IPP did not include the name</p>	W 206			

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W 206	<p>Continued From page 16 of anyone with expertise in training persons with visual and hearing deficits. The IPP contained a directive to staff to sign "sit" to Resident #3 prior to having him sit in a chair and to sign "bathroom" to him prior to using the restroom. The IPP did not contain directions to staff on how they should assist Resident #3 to walk about his home or out in the community.</p> <p>Interview on 4/16/15 with the Qualified Intellectual Disability Professional (QIDP), with Resident #3's record available, verified there was no member of the IDT who was an expert in training persons with visual and hearing deficits. The QIDP verified the IPP contained the directive for staff to sign "sit" with Resident #3 prior to having him sit down. The QIDP further verified that the IPP did not contain specific instructions to staff on how they were to walk with Resident #3. She stated the methods observed were the techniques that had been used with him historically.</p>	W 206		
W 240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that one Expanded Sample Resident's (Resident #3) Interdisciplinary Team (IDT) included an expert in training persons with visual and hearing deficits. This failure prevented Resident #3 from receiving training that was approved, directed and overseen by someone knowledgeable in currently</p>	W 240		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2015
NAME OF PROVIDER OR SUPPLIER CAMELOT GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 9201 2ND AVENUE NORTHWEST SEATTLE, WA 98117		
(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 240	<p>Continued From page 17 accepted training techniques for the visually and hearing impaired.</p> <p>Findings include:</p> <p>See W196 for details of observations.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff walking with Resident #3 both in his home and out in the community. Staff used 3 different techniques: 1. Resident #3 placing one hand on each of the staff ' s shoulders and walking directly behind them; 2. Resident #3 placing one hand on a staff ' s shoulder and his other hand on their upper arm and walking to the staff ' s side; 3. Resident #3 placing his hand on the staff ' s upper arm and walking to the side of the staff.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff working with Resident #3 and having him sit in a chair after walking with the staff. On no occasion did the staff sign " sit " with him prior to having him sit down.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff working with Resident #3 and staff were observed verbally interacting with him and giving him verbal directions. Staff did not accompany these verbal interactions with any other means of communication related to Resident #3 ' s hearing deficit.</p> <p>Review on 4/16/15 of Resident #3 ' s Individual Program Plan (IPP), dated 5/28/14, revealed he is [REDACTED] Review of the list of staff contributing to the IPP did not include the name</p>	W 240		

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W 240	Continued From page 18 of anyone with expertise in training persons with visual and hearing deficits. The IPP contained a directive to staff to sign " sit " to Resident #3 prior to having him sit in a chair and to sign " bathroom " to him prior to using the restroom. The IPP did not contain directions to staff on how they should assist Resident #3 to walk about his home or out in the community.	W 240			
W 247	Interview on 4/16/15 with the Qualified Intellectual Disability Professional (QIDP), with Resident #3 ' s record available, verified there was no member of the IDT who was an expert in training persons with visual and hearing deficits. The QIDP verified the IPP contained the directive for staff to sign " sit " with Resident #3 prior to having him sit down. The QIDP further verified that the IPP did not contain specific instructions to staff on how they were to walk with Resident #3. She stated the methods observed were the ones that had been used with him historically. 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to encourage all Residents to take care of themselves and their home independently. These failures prevented Residents from taking care of themselves as independently as possible. Observation on 4/14/15 at 8:52AM found Staff F washing dishes in the kitchen while Resident #1	W 247			

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W 247	<p>Continued From page 19</p> <p>sat in the living room. Also on 4/14/15 at 9:47AM Staff F was observed sweeping the dining room floor while Resident #1 sat in the living room that was adjacent to the dining room. At 10:12AM Staff A was also observed sweeping the dining room floor while Resident #1 sat in the living room.</p> <p>Observation on 4/14/15 at 9:13 AM revealed staff F was loading the dishwasher. Resident #1 was sitting on the couch manipulating a ball of string.</p> <p>Observation on 4/15/15 at 8: 45 AM revealed Staff F was loading the dishwasher in the kitchen. Resident #1 was sitting on the couch. Resident #1 was not engaged in any activity. Staff F did not approach Resident #1 and ask him to help load the dishwasher.</p> <p>Record review on 4/15/15 of Resident #1 ' s Individual Program Plan revealed under the section titled Prioritized long term goals- #7: " continue to work on maintaining skills needed for activities of daily living."</p> <p>Interview on 4/16/15 with Staff F about engaging residents in household activities revealed "he had never thought about that."</p> <p>Interview with the Qualified Intellectual Disability Professional (QIDP) about the observation revealed the facility is aware some staff "do for Residents" instead of having resident do for themselves.</p> <p>2. Review on 4/15/15 of General Event Report dated 7/2/14 revealed Resident #2 received her morning medications late. She did not receive them until 7:45 AM, which was 15 minutes past the 1 hour window for giving them medications.</p>	W 247		

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W 247	<p>Continued From page 20 The window was from 6:30 AM to 7:30 AM.</p> <p>Interview on 4/16/15 with Staff F revealed he started his shift at 6 AM. He stated he used to work the overnight shift and trained the current overnight staff to do the job. He said the facility routine was for the overnight staff to start waking Residents up at 5:00 AM and begin assisting Residents to get dressed and ready for the day. He said they started at this time in order to ensure all of the Residents were ready to receive their medications at 6:30 AM.</p> <p>Interview on 4/17/15 with the QIDP verified the facility initiated the Residents ' day by getting them up in order to be ready to take their medications starting at 6:30 AM. She stated this was done because of the times the medications were ordered to be given. She verified the Residents were not deciding when to get up to start their day and the facility had not approached the medical staff to order the medications on a schedule which was directed by the Residents ' preferences.</p>	W 247		
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by:</p>	W 249		

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W 249	<p>Continued From page 21</p> <p>Based on observations, record review, and interview, the facility failed to ensure staff consistently implemented one Expanded Sample Resident 's (Resident #3) Individual Program Plan (IPP). The IPP contained instructions related to signing " sit " and " bathroom " to Resident #3, but staff did not do this with Resident #3. The IPP contained a program for using a communication board which was not implemented. Failure to implement Resident #3 ' s IPP put him at risk of not gaining new skills and increasing his independence.</p> <p>Findings include:</p> <p>See W196 for detailed descriptions of observations.</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff working with Resident #3 and having him sit in a chair after walking with the staff. On no occasion did the staff sign " sit " with him prior to having him sit down.</p> <p>Observation on 4/16/15 at 9:17 AM revealed Staff E went to Resident #3 who was sitting in the living room area of the home. Staff E talked to Resident #3 verbally, in soft tones, about using the bathroom. Staff E did not sign " bathroom " to Resident #3. Interview with Staff E revealed he did not know the sign for " bathroom " .</p> <p>Observations of Resident #3 from 4/14/15/ through 4/16/15 revealed at no time did staff use a communication board with him.</p> <p>Review on 4/16/15 of Resident #3 ' s IPP</p>	W 249			

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W 249	<p>Continued From page 22</p> <p>revealed it contained program #2002 to teach Resident #3 to independently sign " bathroom " . The IPP also included program #1421 which directed staff to " sign ' sit ' to [Resident #3 ' s first name] before putting his hand on the chair and his independently sitting down " . The IPP also contained program #2005 to use a communication board.</p> <p>Interview on 4/16/15 with the Qualified Intellectual Disability Professional (QIDP), with Resident #3 ' s record available, verified the IPP contained the training programs for signing " bathroom " and for staff to sign " sit " prior to Resident #3 sitting down. She verified staff should have been implementing these programs. The QIDP revealed program #2005 for the communication board was not being implemented because the staff who was going to make the board was no longer working at the facility. She verified no other program had been started in its place and there were no other programs related to his visual and hearing deficits or communication needs.</p>	W 249		
W 250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to provide Active Treatment Schedules for 3 of 4 Residents (Resident #1 and Resident #2 sampled residents and Resident #3 expanded sampled resident) that directed staff on</p>	W 250		

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W 250	Continued From page 23 how and when to implement training over the course of the Residents ' day. This failure prevented the staff from knowing when and what to be doing with residents throughout the day. Findings Included Record review on 4/17/15 of Resident #1, Resident # 2 and Resident #3 ' s record revealed there were no Active Treatment Schedules. Interview on 4/17/15 with the Qualified Intellectual Disabilities Professional (QIDP) verified there were no Active Treatment Schedule.	W 250		
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 observations, record review, and interview, the facility failed to ensure one Expanded Sample Resident (Resident #3) had a current Comprehensive Functional Assessment (CFA) as it did not include a current assessment of Resident #3 ' s visual and hearing deficits-with accompanying training recommendations. Resident #3 had [REDACTED] but the assessment of these [REDACTED] along with training recommendations was not current. This failure prevented the facility from having current information related to Resident #3 ' s training needs in order to provide a plan which best met his needs.	W 259		

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W 259	<p>Continued From page 24</p> <p>Findings include:</p> <p>See W196 for a detailed description of observations.</p> <p>Review of Resident #3 ' s Individual Program Plan, dated 5/28/14, revealed he has [REDACTED]</p> <p>From 4/14/15 through 4/16/15 numerous observations were made of direct care staff walking with Resident #3 both in his home and out in the community. Staff used 3 different techniques: 1. Resident #3 placing one hand on each of the staff ' s shoulders and walking directly behind them; 2. Resident #3 placing one hand on a staff ' s shoulder and his other hand on their upper arm and walking to the staff ' s side; 3. Resident #3 placing his hand on the staff ' s upper arm and walking to the side of the staff.</p> <p>Review on 4/16/15 of Resident #3 ' s CFA revealed the most current communication assessment was dated 5/31/99.</p> <p>Interview on 4/16/15 with the QIDP, with Resident #3 ' s record available, verified there was no communication assessment which was more current.</p>	W 259			