

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D 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 the result of a Recertification Survey conducted at Camelot Group Home on 4/19/16, 4/20/16, and 4/21/16. The survey was conducted by: Sarah Tunnell Jim Tarr 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			
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 observation and interview, the facility failed to ensure the home was kept in good repair. Observations of the home revealed numerous items in need of cleaning or renovation. This failure prevented the Clients from living in a clean, sanitary home, free of potential hazards. Findings include: Observation on 4/19/16 at 9:47 AM at Camelot Group Home revealed the front and backyard	W 104			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 104	Continued From page 1 grass overgrown 1-2 feet during a facility tour with Staff A. A wooden picnic table had cracked and peeling paint. Observation at 10:14 AM revealed dark stains on the carpet in the living room. In addition, there was a raised lip in the carpet several feet long. Observation at 10:26 AM revealed the floor heating grates in the dining room to be dusty with at least 1 bead stuck in the grate. Observation at 1:52 PM revealed the floor heating vent near the front entrance full of debris. The kitchen floor heating vent was observed to be white in color but with black grime coating the surface. Observation on 4/20/16 at 12:14 PM revealed dust on the sprinkler head near the kitchen entry and on the sprinkler head in the kitchen. Interview on 4/21/16 at 9:10 AM with Staff A and B revealed the lawn mower was broken. The staff acknowledged the other issues of cleanliness and disrepair in the home.	W 104			
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 Qualified Intellectual Disability Professional (QIDP) failed to ensure clients' active treatment programs provided clear instructions on skill training programs for 2 of 3 Sample Clients (Client #2 and #3) which would ensure that all staff across all days and shifts would train these Clients in exactly the same way. This failure put Clients at risk of not receiving consistent training on needs identified as important and potentially	W 159			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 2</p> <p>put Clients at risk of not learning skills which would allow them to become more independent.</p> <p>Findings include:</p> <p>Record review on 4/20/16 of Client #2's Individual Program Plan (IPP) dated 5/21/15 revealed goals to assist Client #2 in becoming independent with cleaning the dining table and using American Sign Language (ASL) to communicate his need to use the bathroom. Client #2 was diagnosed as [REDACTED]. The Data Sheets for Objective 2002: Increased Expressive Communication Skills for the period of January 2016 to April 2016 revealed the portion of the teaching plan which described how to teach Client #2 using deaf-blind ASL techniques could not be read. The paperwork was dark and the words were not legible. The Data Sheets for Objective 1303: Household Chores for the period of February 2016 to April 2016 revealed the portion of the teaching plan which describes how to teach Client #2 could not be read. The paperwork was dark and the words were not legible.</p> <p>Record review on 4/20/16 of Client #3's IPP dated 4/30/15 revealed a money management goal to identify coins on a worksheet. The Coin Value Worksheet for the period of November 2015-April 2016 revealed Client #3 was required to draw a line to match each coin to its value. The coins on the worksheet were dark and difficult to identify.</p> <p>Interview on 4/21/16 at 9:10 AM with Staff A and B verified the documents for Clients #2 and #3 could not be read.</p>	W 159			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 199 W 199	Continued From page 3 483.440(b)(2) ADMISSIONS, TRANSFERS, DISCHARGE Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their admission decision was based on a preliminary evaluation of 1 of 1 Expanded Sample Clients (Client #4). This failure prevented the facility from meeting his nutritional needs and prevented them from ensuring his rights were maintained. Findings include: 1. Observation on 4/20/16 at 1:04 PM at Camelot Group Home revealed Client #4 was drinking tea from a reusable coffee cup with a lid during lunch. Record review on 4/20/16 of a single sheet of paper entitled Discharge Individual Program Plan (DIPP) dated 4/1/16, for Client #4, revealed he was discharged from his previous living arrangement on [REDACTED] 16. The DIPP did not include a summary of Client #4 for the following areas: functional developmental, behavioral, social, health, and nutritional status. Review of Patient Clinical Review Summary from Puget Sound Gastroenterology dated 1/7/16 revealed Client #4 was to continue a [REDACTED] diet after a choking incident. The [REDACTED] diet was described as "mechanical soft food, drink fluids at room temperature through a straw during meals."	W 199 W 199			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 199	Continued From page 4 Interview on 4/21/16 at 9:10 AM with Staff A and B revealed the only preliminary planning documentation prior to his admit to Camelot Group Home was the DIPP. They revealed they thought the diet order for a straw had been discontinued. After the interview, staff looked for updated documentation but could not produce a diet order change after the Puget Sound Gastroenterology order on 1/7/16. 2. Observation on 4/20/16 at 11:45 AM at Camelot Group Home revealed Client #4 put his upper front (teeth) bridge in the med room with staff assistance after finishing a snack. Observation at 1:00 PM revealed Client #4 went into the med room with staff to retrieve his upper front bridge before lunch. Record review on 4/20/16 revealed Client #4 was admitted to the facility on [REDACTED] 16. Client #4 did not have consent to lock his upper front bridge and compression socks in the med room. Interview on 4/21/16 at 9:10 AM with Staff A and B verified Client #4 did not have consent to lock his upper front bridge and revealed his compression socks were also locked in the med room.	W 199			
W 229	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by:	W 229			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 229	Continued From page 5 Based on record review and interview, the facility failed to ensure 1 of 3 Sample Clients (Client #1) had an objective that was written in singular fashion with only one discrete behavior being trained and monitored. Failure of the facility to ensure objectives were written in a singular format prevented the facility from ensuring staff focused their training on a specific skill. This failure also prevented the facility from ensuring follow-up occurred which would allow them to determine whether progress was occurring. Findings include: Record review on 4/20/16 of Client #1's Individual Program Plan (IPP) dated 11/4/16 (verified as misdated by the Qualified Intellectual Disability Professional) revealed he had a need to increase his laundry skills. Objective #1302 included the skill of washing his laundry and the skill of drying his laundry.	W 229			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION 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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide Active Treatment Schedules for 3 of 3 Sample Clients (Client #1, #2, and #3) which directed staff on how and when to implement	W 250			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 250	Continued From page 6 active treatment over the course of the Clients ' day. This failure prevented each client from having staff who knew what activities to teach and when to teach them throughout their day. Findings include: Record review on 4/20/16 for Client #1, Client # 2, and Client #3 revealed Active Treatment Schedules (undated) that only provided one-word general instructions to staff such as sleep, shower, leisure, snack, senior center, and the type of meal were the descriptions for what the Clients should do each day of the week. Interview on 4/21/16 at 9:10 AM with Staff B verified the Active Treatment Schedules needed more details.	W 250			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure data was collected on skill training objectives as described in the Clients ' Individual Program Plans (IPP) for 2 of 3 Sample Clients (Client #2 and #3). This failure prevented the facility from determining Client progression or regression. Findings include:	W 252			

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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	<p>Continued From page 7</p> <p>Client #2</p> <p>Record review on 4/20/16 of Client #2 's IPP dated 5/21/15 revealed goals to assist Client #2 in becoming independent with cleaning the dining table, unlocking his bedroom door independently, and using American Sign Language (ASL) to communicate his need to use the bathroom.</p> <p>1. The Data Sheets for Objective 2002: Increased Expressive Communication Skills revealed " Obtain data: [Client #2 first name] will work on this objective 3 times per week. " The Data Sheet for April 2016 revealed data had been documented twice per week for the first 2 weeks of April. The Data Sheet for March 2016 revealed the data had been documented twice in the first week and twice in the second week.</p> <p>2. The Data Sheets for Objective 1303: Household Chores revealed " Obtain data: [Client #2 's first name] will work on this objective 2 times per week. " The Data Sheet for April 2016 was blank as of 4/20/16. The Data Sheet for March 2016 revealed data had not been documented the first two weeks of March, was documented once the third week, and once the fourth week.</p> <p>3. The Data Sheets for Objective: Independent Living Key Program revealed " Obtain Data: 3 times weekly. " The Data Sheet for April 2016 revealed data had been documented once the first week and once the second week.</p> <p>Interview on 4/21/16 at 9:10 AM with Staff A and B verified data had not been collected correctly.</p> <p>Client #3</p>	W 252			

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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	Continued From page 8 Record review on 4/20/16 of Client #3's IPP dated 4/30/15 revealed Money/Budgeting objective (Need Number 1303) to teach her how to " independently correctly count her money in order to know how much money she has, 10 out of 10 times before her next IPP 5/2016. " Client #3 was working on the first of a four step program where she matched pictures of coins with their value. Staff were to collect data on Step 1 three times per week. Client #1's data sheets for this objective revealed: November 2015 the program was run two times; December 2015 the program was run once; January 2016 the program was run once; February 2016 the program was run four times and for March 2016 the program was run two times. Interview with Staff B on 4/21/16 at 9:50 AM verified staff were not running Client #3's objective for counting money as often as required by her IPP.	W 252			
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a completed objective for 2 of 3 Sample Clients' (Client #1 and #2) Individual Program Plans (IPP) was identified, modified or changed to meet the needs or accomplishments of the Client. This failure prevented Clients from having new skills taught	W 255			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 255	<p>Continued From page 9 and from becoming more independent in other life skills.</p> <p>Findings include:</p> <p>Client #1</p> <p>Observation on 4/19/16 at 1:45 PM at Camelot Group Home revealed Client #1 independently brought his laundry basket to the laundry room.</p> <p>Record review on 4/20/16 of Client #1's IPP dated 11/4/16 (verified as misdated by the Qualified Intellectual Disability Professional (QIDP)) revealed he had a need to increase his laundry skills. Objective #1302 to address this need stated Client #1 would wash and dry his laundry two times per week with only verbal prompts or independently to achieve success with the skill.</p> <p>Record review on 4/20/16 of Client #1's QIDP Annual Review November 2015 stated for Objective: Household Skills: Increase Laundry Skills; " This goal had been met and will be discontinued. "</p> <p>Interview on 4/21/16 at 9:50 AM with Staff B verified Client #1 had achieved his objective for his Laundry skills program and a new program for a new need had not been started.</p> <p>Client #2</p> <p>Record review on 4/20/16 of Client #2's IPP dated 5/21/15 revealed a goal to assist Client #2 in using American Sign Language (ASL) to communicate his need to use the bathroom. The objective stated: "[Client #2 first name] will</p>	W 255			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 255	Continued From page 10 independently sign " bathroom " 10 out of 10 times by his next IPP, 5/2015. " Review of Data Sheets for the period of January 2016 to April 2016 revealed Client #2 met this goal in January 2016 and continued to be independent. Interview on 4/21/16 at 9:10 AM with Staff A and B verified programs are supposed to be updated as client ' s progress. Staff verified this had not occurred.	W 255			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure restrictive programs for 3 of 3 Sample Clients (Client #1, #2, and #3) and 1 of 1 Expanded Sample Clients (Client #4) were conducted with the written, informed consent of the client, parent, or legal guardian. Clients did not have access to laundry soap and Client #4 did not have unrestricted access to his upper front (teeth) bridge and compression socks. This failure prevented the Clients from independently laundering their clothes and accessing personal items. Findings include: 1. Observation on 4/19/16 at 9:47 AM at Camelot Group Home revealed laundry soap locked in a cabinet in the laundry/med room	W 263			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 263	<p>Continued From page 11 during a facility tour with Staff A.</p> <p>Record review on 4/20/16 of Client #1, #2, and #3 's Individual Program Plans (IPP) revealed no mention of the need to lock laundry soap. Client #1 's IPP dated 11/14/16 (verified as misdated by the Qualified Intellectual Disability Professional), Client #2 's IPP dated 5/21/15, and Client #3 's IPP dated 4/30/15.</p> <p>Interview on 4/21/16 at 9:10 AM with Staff A and B verified the laundry soap was locked and staff must unlock the cabinet for clients.</p> <p>2. Observation on 4/20/16 at 11:45 AM at Camelot Group Home revealed Client #4 put his upper front (teeth) bridge in the med room with staff assistance after finishing a snack. Observation at 1:00 PM revealed Client #4 went into the med room with staff to retrieve his upper front bridge before lunch.</p> <p>Record review on 4/20/16 revealed Client #4 was admitted to the facility on [REDACTED] 16. Client #4 did not have consent to lock his upper front bridge and compression socks in the med room.</p> <p>Interview on 4/21/16 at 9:10 AM with Staff A and B verified Client #4 did not have consent to lock his upper front bridge and revealed his compression socks were also locked in the med room.</p>	W 263			
W 445	<p>483.470(i)(2)(i) EVACUATION DRILLS</p> <p>The facility must actually evacuate clients during</p>	W 445			

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

PRINTED: 06/08/2016
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 04/21/2016
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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 445	<p>Continued From page 12 at least one drill each year on each shift.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all clients actually evacuate during at least one drill each year on each shift. This failure resulted in clients and staff not rehearsing for emergencies and put all Clients and staff at risk of not evacuating quickly and safely during an emergency.</p> <p>Findings include:</p> <p>Record review on 4/20/16 of all Fire Drill Log Forms 203 and 204 held in 2015 and 2016 revealed the following: Clients are not listed on any Fire Drill Logs.</p> <p>Interview on 4/20/16 at 9:39 AM with Staff A and B verified the form does not list the clients who participated in the drill.</p>	W 445			