

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

PRINTED: 12/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2013
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NAME OF PROVIDER OR SUPPLIER BARCLAY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5027 NORTHEAST 188TH SEATTLE, WA 98155
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W 000	INITIAL COMMENTS This report is the result of an Annual Recertification Survey conducted at Barclay Group Home from 10/27/13 through 10/29/13. A sample of 3 residents were selected from a census of 5. The expanded sample included 2 current residents. The survey was conducted by: Claudia Baetge, M.A. Terry Patton, B.S.N. The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Services Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600 Telephone: (360) 725-2419 Fax: (360) 725-2642	W 000	W - 107 The company implemented a new policy stating that the new employee's date of hire will be after the new employee has completed the initial step of the TB test process unless they can get a TB test done outside of the agency, prior to working directly with clients. This policy was put in place on 10/25/2013 at the Camelot Society's Supervisory Meeting where the Facility Manager and QIDP attended. The record review of Staff A showed that the initial TB test was done 3 years, 2 months, 11 days from hire date. This is not accurate. This was the most recent TB test done for Staff A, as TB tests are done every year. The record review of Staff G & I was also inaccurate.	
W 107	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 health. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to comply with State Regulation (WAC 388-78A-2480) related to ensuring each staff is screened for tuberculosis within three days of employment. This failure placed 3 of 3	W 107	RECEIVED DEC 17 2014 DSHS-ADSA Residential Care Services ICF/MR Program	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 12/12/13
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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 107	Continued From page 1 sampled residents (Resident #1, #3 and # 4) and 2 of 2 expanded sampled residents (Resident #2 and #5) at risk for potential exposure to the tuberculosis virus. Findings include: WAC 388-78A-2480 requires the facility to: develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment. Refer to attached Statement of Deficiencies, dated 10/29/13, for details of failed practice under WAC 388-78A-2480.	W 107	W - 108 Residents have been residing in this facility for the past 30+ years, and this issue hasn't been addressed previously, nor have there been any reported incidents or concerns of safety. However, the maintenance supervisor will build a retaining wall to prevent the residents from falling while using that exit. This will be completed by January 6 th , 2014. During the annual survey conducted on 12/28/12, the issue of the erosion of the steps/foundation was addressed. Due to the cost, our plan of correction was to restrict the area (which entailed locking the door so that no one could access those steps) the steps could be fixed. This plan of correction was approved. This year during the annual survey, the fire marshal stated that that door cannot be locked as it should be considered an escape route in case of a fire. The door is no longer restricted, and the fire marshal stated that the steps do not appear to be a potential safety issue. The maintenance supervisor obtained a second opinion on the steps and it was determined that just the bottom step needs repaired/leveled. The steps will be repaired January 6, 2014.		
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 and interviews, the facility failed to comply with State Regulation (WAC 388-78A-3080) and (WAC 388-78A-3090) ensuring areas outside of the house are safe for residents to use. This failure placed 3 of 3 sampled residents (Resident #1, #3 and # 4) and 2 of 2 expanded sampled residents (Resident #2 and #5) at risk for harm and injury on the facility grounds. Findings include:	W 108			

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W 108	Continued From page 2 WAC 388-78A-3080 Requires the facility to have handrails and guardrails when necessary for resident safety. WAC 388-78A-3090 Requires the facility to keep the facility grounds and structure safe and in good repair. Refer to attached Statement of Deficiencies, dated 10/29/13 for details of failed practices under WAC 388-78A-3080 and WAC 388-78A-3090.	W 108	Because the door was restricted, the residents could not use it as an evacuation route so there was no potential risk of tripping over garbage and recycling bins during an emergency. Because the door is no longer restricted, the bins will now be lined up alongside the house (overseen by the Facility Manager) in order to leave space and room for residents and staff to exit in case of an emergency. The facility manager will check the bins on Wednesdays to ensure that the bins are not scattered throughout the grass. This item will be resolved by December 18 th , 2013.		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to secure resident health care records for 3 of 3 sampled residents (Resident #1, #3 and #4) and 2 of 2 expanded sampled residents (Resident # 2 and #5). This failure violated residents' rights to keep their medical information confidential. Findings include: All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated. Observation on 10/27/13, revealed client profile records were printed and displayed on the bulletin board in the kitchen area, visible to all residents	W 112	The Facility Manager will do a monthly walk of the exterior of the facility to ensure that there are no health and safety concerns. Any noted issues will be addressed by fixing the issue if possible or submitting a maintenance request. The maintenance supervisor will remove the barbed wire and will fix the hole in the fence. This will be completed by January 6 th , 2014.		

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W 112	Continued From page 3 and other guests to the facility. Record review of displayed client profile information revealed the following: resident name, DOB, diagnosis, psychotropic medications, behavior support plan, day program, adaptive equipment, and restrictive consents. Interview with staff A & B acknowledged client profiles should not have been posted on bulletin board.	W 112	W- 112 The client profile was taken down immediately once the concern was brought up. Any confidential information will be kept in the facility manager or QIDP's office, or will be kept in binders that will not be visible to those who should not have access to confidential information. This will be monitored by the Lead ISC and/or Facility Manager.		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (Resident #3 and #4) continuous active treatment programs were based on residents ' needs, monitored, coordinated and revised, as required. This failure placed residents ' at risk for diminished ability of skill development/ independence. Findings Include: All record reviews and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated. Resident #3 Record review of Resident #3 ' s Individual Program Plan (IPP) dated 9/4/13, revealed an	W 159	W - 159 Resident #4's data sheets for meal preparation and the objective number in the IPP were revised so that they match. Regarding the discrepancies/conflicts between programmatic, medical and dietary for Resident #4, the facility manager will schedule a meeting with the nutritionist, as well as with Resident #4's PCP to determine if 6 small meals daily are needed and if so, a menu plan will be developed. It is true that Resident #4 does enjoy the food items listed; however he does not eat these foods daily or even on a regular basis. The staff encourages him to make healthy choices. The QIDP will alter the plan in order to keep dietary recommendations and IPP objectives consistent.		

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W 159	<p>Continued From page 4</p> <p>Active Treatment Program with identified need as: " Assist with Meal Preparation " and identified task as Need Number: 1301. The objective for Resident #3: " Participate in preparing a meal twice a week (at 100% compliance) for 6 consecutive months by 9/4/14 "</p> <p>Record review of the Data Sheet used by staff to collect this data, was titled task: " Participate in Cooking /Baking " and identified Objective Number: 2002. However, Resident #3 ' s IPP dated 9/4/13 revealed that Need Number: 2002 as, " Increase the use of sign language " .</p> <p>Record review of the data collected on Data Sheet Objective Number: 2002 and task: " Participate in Cooking/Baking " for October 2013 revealed the following data: 10/10/13 helped set table; 10/13/13 served juice; 10/15/13 helped to set the table; 10/24/13 helped with salad.</p> <p>Resident #4 Record review of Resident #4 ' s IPP 9/12/13 revealed an active treatment program with identified need as: " Maintain Participation in Meal Preparation " . The plan for implementing this active treatment program included the following steps:</p> <ul style="list-style-type: none"> • Items that Resident #4 enjoys include: macaroni and cheese, fettuccine alfredo, and polish sausage, and bologna sandwiches, omelets, etc. • Resident #4 should be encouraged to limit his salt intake due to high blood sugar. • Resident #4 should limit his sweets due to mildly high LDL level and his hypoglycemia. <p>However, record review of Quarterly RN Summary dated 8/30/13 revealed Resident #4 is</p>	W 159			

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W 159	Continued From page 5 to have six small meals a day that follow GERD guidelines. Physician orders dated 9/01/13 for Resident #4 revealed he is prescribed 40 mg of Omeprazole for gastric distress, every morning to prevent heartburn and to have 6 small meals a day. Interview with Staff J revealed that macaroni and cheese, fettuccine alfredo, polish sausage, bologna sandwiches, and omelets are usually high fat foods which Resident #4 should not have. QIDP failed to ensure any discrepancies/conflicts between programmatic, medical and dietary were resolved.	W 159	Going forward, the QIDP will ensure that there are no discrepancies between reports/assessments when completing semi-annual reviews. Any such concerns will be researched and corrected during the review period. All items will be completed by January 6 th , 2014. W - 196 Prior to completing CFA's, the QIDP will review the ISC daily assessment to ensure that the CFA and assessment is accurate and consistent. They will also consult with the Facility Manager and staff for input.	
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 the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to provide 2 of 3 sampled residents (Residents #3 and #4) Active Treatment that is based on residents' needs and strengths, identified a planned and logical sequence for learning new life skills, and maintained residents' current level of functioning	W 196	A new form for both residents #3 & #4 was created that states what they assisted with during meal prep, and what cue was needed for each step. Facility Manager will train staff on how to properly document programs at the next staff meeting on December 16 th , 2013. Since survey, a new data form was created in order to track how the resident assisted and what cue was needed for Resident's #3 and #4.	

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W 196	<p>Continued From page 6</p> <p>while building on demonstrated skills. This failure placed residents at risk for deterioration of residents' skills and abilities, increases residents' dependence on others and prevents residents from developing their optimal self-determination.</p> <p>Findings Include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Comprehensive Functional Assessment (CFA):</p> <p>Observation of Resident #3 revealed he was able to understand and physically respond to verbal cues.</p> <p>Resident #3 was observed: independently getting his own glass and flatware prior to lunch; eating, drinking, using his napkin independently; getting in the kitchen refrigerator independently and pouring himself a glass of flavored water; picking up his dishes, wiping off the table, disposing of his napkin and scraping his plate in the garbage; putting his plate, flatware, and glass in the sink for washing.</p> <p>Observation of Resident #4 revealed he was able to understand and verbally respond to conversations and verbal cues.</p> <p>Resident #4 was observed: independently getting his own glass and flatware prior to lunch; eating, drinking and using his napkin independently; independently pouring himself a glass of flavored water; picking up his dishes and placing his leftover food in a Tupperware type container;</p>	W 196	<p>In the future, IPPs and plans will be adjusted and revised in order to build on skills that residents possess in order to prevent regression.</p>	

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W 196	<p>Continued From page 7</p> <p>disposing of his napkin in the garbage, putting his plate, flatware, and glass in the sink for washing. Resident #4 did have a key which would open door padlocks on pantry cupboard and pantry refrigerator where food was kept locked. However, was unable to open the padlocks with the key unless he had staff assistance.</p> <p>Record review revealed the facility had not provided a consistent and accurate CFA for Resident #3 and #4 as evidenced by:</p> <ol style="list-style-type: none"> 1. Resident #3 's Comprehensive Functional Assessment for Individual Program Plan dated 9/04/13 revealed resident is able to: open containers, mix foods, make simple breakfast and sandwiches, make coffee, set the table for meals and clean up afterwards. 2. Resident #3 's ISC Daily Living Skills Assessment dated 9/4/12 and the ISC Daily Living Skills Assessment completed in September of 2013 revealed facility staff report Resident #3 is unable to independently operate appliances, prepare simple foods, wash dishes, wipe tables and counter tops. 3. Resident #4 's Comprehensive Functional Assessment for Individual Program Plan dated 9/12/13 revealed no cooking related skills that Resident #4 was independent at. Resident #4 needs a lot of assistance to remain focused and will often choose not to participate in activities. 4. Resident #4 's ISC Daily Living Skills Assessment dated 8/29/13 revealed facility staff report Resident #4 is unable to independently operate appliances or prepare simple foods. <p>Individual Program Plan</p> <p>The facility had not provided an Individual</p>	W 196			

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W 196	<p>Continued From page 8</p> <p>Program Plan (IPP) for Residents #3 and #4 which provided discrete, measureable and criteria based objectives that helped Residents #3 and #4 learn to function with as much self-independence as possible as evidenced by the following record reviews:</p> <ol style="list-style-type: none"> 1. Resident #3 's IPPs dated 9/03/09, 9/8/11, 9/5/12, and 9/4/13 revealed that resident has been on the same training objective and implementation plan for: " Participate in preparing a meal twice a week " , without change. 2. Resident #3 's ISC Daily Living Skills Assessment dated 9/4/12 and the ISC Daily Living Skills Assessment completed in September of 2013 revealed facility staff reported: Resident #3 can no longer independently operate appliances, prepare simple foods or wash dishes and wipe tables and counter tops. 3. Resident #4 's IPPs dated 9/15/11 and 9/12/13 revealed that Resident #4 has been on the same training objective and implementation plan: " participate in preparing a meal twice a week " , without change. 4. Resident #4 's ISC Daily Living Skills Assessment dated 8/24/13 revealed facility staff report Resident #4 can no longer independently operate appliances (TV, toaster, etc.) or prepare simple foods although he did have these skills in 1998 and 2002. <p>IPP (participate in preparing a meal twice a week) for Resident #3 and #4 remained unchanged and demonstrated residents ' regressed in meal preparation skills.</p> <p>Individual Program Plan Implementation</p> <p>The facility had not provided a continuous active</p>	W 196			

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W 196	<p>Continued From page 9</p> <p>treatment program for Resident #3 and Resident #4 of needed interventions and services in sufficient intensity and frequency to help residents achieve their IPP objectives as evidenced by:</p> <ol style="list-style-type: none"> 1. Resident #3 ' s IPPs dated 9/30/09, 9/8/11, 9/5/12, and 9/4/13 revealed an active treatment program with same training objective: " participate in preparing a meal twice a week " . The implementation plan for this objective included the below methods: <ol style="list-style-type: none"> a. Encourage Resident #3 to choose the meal he would like to make (he has enjoyed making stir-fry meals in the past) on Thursdays and Saturdays or Sundays. Encourage him to pack the leftovers to be used for his lunch as this seems to be what he prefers (vs. sandwiches). b. If Resident #3 chooses to make stir-fry over rice, prior to cooking, encourage Resident #3 to sign " rice " . c. Encourage Resident #3 for some or all of the ingredients needed for meals as often as possible. Uwajimaya, Central, or Ranch Market carry Asian specialty foods. d. Record data on the program data sheet located in his program book, under the " Training " tab. e. Notify QIDP if Resident #3 loses interest in assisting with meal prep. f. Encourage Resident #3 to assist with other meals, such as making his own lunch. g. Encourage him to clear his dishes to the kitchen after eating meals. 2. Resident #4 ' s IPP dated September 12, 2013, revealed an active treatment program for household skills with training objective: " participate in preparing a meal twice a week (at 	W 196			

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W 196	<p>Continued From page 10 100% compliance) for twelve consecutive months ". The implementation plan for this objective included the below methods:</p> <ul style="list-style-type: none"> a. Program data to be recorded two times per week on days Resident #4 chooses. Staff to document data on the program data sheet filed under the " Training " tab in the program book. b. Items that Resident #4 enjoys include: macaroni and cheese, fettuccine alfredo, and polish sausage, and bologna sandwiches, omelets, etc. c. Resident #4 should be encouraged to limit his salt intake due to high blood sugar. d. Resident #4 should limit his sweets due to mildly high LDL level and his hypoglycemia. e. Encourage Resident #4 to help make his own breakfast and lunch as often as possible. f. Encourage Resident #4 to clean up his own dishes after meals. g. Remind Resident #4 to wash his hands prior to participating in meal preparation. <p>Implementation plan methods for Resident #3 and 4 did not offer residents the opportunity to learn new skills that would increase self-determination and independence.</p> <p>Program Documentation</p> <p>The facility failed to provide a system of documentation which provided for collection of accurate, systematic, behaviorally stated data in regard to Resident #3 ' s and #4 ' s performance towards meeting the criteria stated in the IPP objectives, as evidenced by:</p> <p>Record review of Resident #3 ' s Data Sheet revealed that in June of 2013, Resident #3 met</p>	W 196		

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W 196	<p>Continued From page 11</p> <p>the objective of participating in preparing a meal two times a week.</p> <p>The data recorded by the staff on the data sheet revealed the following:</p> <ol style="list-style-type: none"> 6/1/13 the Data Sheet showed Resident #3 " mixed salad " . The section on the data sheet for staff to identify cuing was left blank. 6/6/13, 6/13/13, 6/27/13, and 6/29/13 the Data Sheet showed Resident #3 " stir food " . The section on the data sheet for staff to identify cuing was left blank. 6/8/13 the Data Sheet showed Resident #3 " stirred salad " . 6/16/13 the Data Sheet showed Resident #3 " Fruit " . The section on the data sheet for staff to identify cuing was left blank. 6/20/13 the Data Sheet showed Resident #3 " Soup " . The section on the data sheet for staff to identify cuing was left blank. <p>Record review of the QIDP assessments revealed that in June of 2013, Resident #4 successfully met the objective of helping to prepare a meal two times a week on 9 of 9 occasions.</p> <p>Data recorded by staff on the data sheet in June of 2013 revealed:</p> <ol style="list-style-type: none"> 6/1/13, 6/8/13, 6/12/13, 6/15/13, 6/18/13 and 6/19/13 - " Sandwich " cue to assist: " gesture " 6/2/13, 6/3/13 and 6/5/13 - " granola bar " cue to assist: " independent " 6/26/13 - " mashed potato " cue to assist: " gesture " 6/29/13 - " pasta " cue to assist: " gesture " 	W 196			

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W 196	Continued From page 12 Meal Preparation data for Resident #3 and Resident #4 was not monitored to address missing documentation. Data collected for Resident #3 and #4 did not align with objective to ensure analysis was an accurate reflection of residents ' progress in meal preparation program. Program Monitoring and Change Record review revealed the facility failed to review, update, and modify IPPs ' for Resident #3 and #4 to precisely identify how the facility may help residents ' meet their objectives and build upon learned skills to increase self-determination and independence. 1. Resident #3 ' s IPPs dated 9/30/09, 9/8/11, 9/5/12, and 9/4/13 revealed an active treatment program with the same training objective: " Participate in preparing a meal twice a week " with no changes to implementation plan. 2. Resident #4 ' s IPP dated September 12, 2013 revealed an active treatment program for household skills with training objective: " Participate in preparing a meal twice a week " with no changes to implementation plan. Interview with staff A revealed the facility began the training objective: Participate in preparing a meal twice a week for Resident #3 in 10/99 and Resident #4 in 10/01.	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:	W 206			

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W 206	<p>Continued From page 13</p> <p>(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and</p> <p>(ii) Designing programs that meet the client's needs.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to include dietary input from the Physician, Registered Nurse and Registered Dietician when developing the Individual Program Plan (IPP) for 2 of 3 sampled residents (Residents #3 and #4). This failure to include dietary requirements in dietary related active treatment programs placed residents at risk for continued health problems that their special diets were created to eliminate.</p> <p>Findings include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Resident #3</p> <p>Record review of Resident #3 's Physicians Orders dated 9/21/13 and the Registered Nurse Quarterly Assessment dated 8/30/13 revealed Resident #3 is to have a high calorie, high iron daily diet.</p> <p>Record review of Resident #3 's IPP dated 9/4/13 revealed an objective that resident will participate in preparing a meal twice a week, but does not mention Resident #3 should receive a high calorie/high iron diet.</p>	W 206	<p>W - 206 The RN conducts an annual assessment that aligns with the resident's IPP date. Issues and concerns brought up by the RN are discussed at the IPP meetings for both resident #3 and #4. Next quarterly review for both residents (March 2014), the QIDP will adjust the plan to reflect the dietary concerns and guidelines addressed by the RN, PGP, and nutritionist. Going forward, prior to IPPs, the QIDP will consult with nutritionist to see if there are any recommendations or adjustments needed prior to implementing new IPP Objectives for residents with dietary restrictions/special needs.</p>		

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W 206	Continued From page 14 Interviews with Staff J and Staff K revealed they knew Resident #3 had a high calorie/high iron diet but did not participate in the development of Resident #3 ' s Individual Program Plan. Resident #4 Record review of Resident #4 ' s Physicians Orders dated 9/1/13, Registered Nurse Quarterly Assessment dated 8/30/13 and the Annual Nutrition Assessment dated August 11, 2010 revealed resident is to have a regular diet of six small meals a day that follow Gastric Esophageal Reflux (GERD) guidelines to limit fatty foods. Record review of Resident #4 ' s IPP dated 9/12/13 revealed an objective that resident will participate in preparing a meal twice a week. The guidelines for this objective revealed the following comments: " enjoys macaroni and cheese, fettuccine alfredo, polish sausage, bologna sandwiches, and omelets, etc. " The food listed are high in fat and the guidelines did not mention that Resident #4 should have a regular diet of six small meals a day that follow Gastric Esophageal Reflux (GERD) guidelines to limit fatty foods diet.	W 206			
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247			

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W 247	Continued From page 15 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to provide food choices and self-management opportunities to 3 of 3 sampled residents (Residents #1, #3 and #4) during lunch. This failure resulted in residents not being allowed to exercise choice and self-management during meals. Findings include: All observations and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated. Observations of Residents #1, #3 and #4 during lunch on 10/28/13 revealed Staff D prepared tuna salad sandwiches and tuna salad for lunch and served the sandwiches and salads to Residents #1, #3 and #4. Staff D did not ask Residents #1, #3 and #4 what they would like for lunch and did not offer any lunch choices to residents. Interview with Resident #4 revealed he does not make his lunch at the facility.	W 247	W - 247 The facility manager and QIDP addressed this during staff meetings on 10/22/13 and 11/5/13. There will be a retraining on active treatment during the staff meeting on December 31, 2013 by the Facility Manager. The statement that Resident #4 does not make his lunch at the facility is not accurate. Staff encourage resident #4 to participate, however resident #4 is not always willing to assist staff in preparing lunch and would rather just make the juice. Staff will be retrained on how to properly document that Resident #4 was given the opportunity to assist in making lunch, but refused. This retraining will occur during the staff meeting on December 16 th , 2013 by the Facility Manager.		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide 1 of 1 sampled residents (Resident #1) with	W 322	W - 322 The Facility Manager will document in the Summary of Visits form the appointments and when the next scheduled one should be. The Facility Manager will make sure that staff is scheduling the next appointment prior to leaving the doctor's appointment.		

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W 322	<p>Continued From page 16</p> <p>recommended Podiatry appointments for bi-monthly toe nail trim as directed by nursing orders. This failure placed Resident #1 at risk of harm for medical issues which could lead to deterioration in his overall health.</p> <p>Findings include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Observation on 10/28/13 of Resident #1 's feet revealed long toes nails (approximately 1/4 inch) that were chipped and cracked. Notable fungus was present on Resident #1 's toenails.</p> <p>Record review of Comprehensive Functional Assessment dated 1/10/13 revealed Resident #1 's toenails are Mycotic and debrided by a Podiatrist every 8 weeks. Summary of Visits from 8/24/12 to 9/21/13 revealed: Resident #1 was seen by Podiatrist on 12/26/12 with notation that next appointment was to be scheduled in 4-6 weeks. Resident #1 was not seen by Podiatrist until 5/22/13 with notation that next appointment was to be scheduled in 6 weeks. Resident was not seen by Podiatrist until 8/15/13 with notation that next appointment was to be scheduled in 2 months.</p> <p>Record review of Pharmacy Quarterly report dated 10/11/13 revealed resident was last seen by Podiatrist on 8/15/13.</p> <p>Interview with Resident #1 acknowledged his feet hurt yet was unable to explain why they hurt.</p>	W 322	<p>The Facility Manager will address this at the December 31st staff meeting, so all staff are aware to schedule appointments prior to leaving the doctor's office so that the follow-up appointments occur and are not overlooked. The Facility Manager will also look at the Summary of Visits form every two weeks to ensure that appointments are being scheduled, starting December 23rd, 2013.</p>		
W 330	483.460(b)(2) PHYSICIAN PARTICIPATION IN	W 330			

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W 330	<p>Continued From page 17 THE IPP</p> <p>If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to include physician participation either in person or in writing when updating the Individual Program Plan (IPP) for 2 of 3 sampled residents (Residents #3 and #4). This failure to include information from the physician regarding residents' special diets places residents at risk of exacerbation of their health problems.</p> <p>Findings include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Both Resident #3 and Resident #4 have health issues for which the physician has ordered special diets.</p> <p>Review of Resident #3's records revealed:</p> <ul style="list-style-type: none"> Physicians Orders dated 9/21/13 revealed resident is to have a high calorie, high iron daily diet. IPP dated 9/14/13 did not reveal information that resident was to have a high calorie/high iron diet. Review of Resident #3's chart on 10/28/13 revealed no History and Physical findings or other documentation by the physician. 	W 330	<p>W - 330 History and Physical forms will be completed by the primary care physician annually and these documents will be used by the QIDP while completing the resident's IPP. The resident's health and dietary needs will be addressed in the IPP, if necessary. However, the History and Physical exam does not correlate with the IPP dates for most residents. If this is case, the QIDP will use the RN annual assessments and will follow up with the nutritionist prior to the IPP. The QIDP will ensure that the H&P matches that of the RN and nutritionist after H&P is completed.</p>		

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W 330	Continued From page 18 Review of Resident #4 's records revealed: · Physicians Orders dated 9/1/13 revealed Resident #4 is to have a regular diet of six small meals a day that follow Gastric Esophageal Reflux (GERD) guidelines to limit fatty foods. · IPP dated 9/12/13 did not reveal information of resident having GERD and needing 6 small meals a day. · Review of Resident #4 's chart on 10/28/13 revealed no History and Physical findings or other documentation by the physician. Interview with Staff A acknowledged physician had not participated in IPP meetings or provided written information for Residents #3 and #4 IPP 's.	W 330		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to follow the nursing treatment plan for 1 of 1 sampled resident (Resident #1) regarding use of compression hose. This failure placed resident at risk of having cardiovascular complications and further deterioration of Resident #1 's health. Findings include: All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.	W 339	W - 339 Resident #1 has stated in the past that the compression socks are too tight. The Facility Manager will put this on monthly achievement sheet in order to document whether or not Resident #1 wears his compression socks or if he refuses. This will be completed by January 1 st , 2014.	

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W 339	Continued From page 19 Record review of RN Quarterly Physical Assessment dated 7/05/13 revealed Resident #1 has significant varicose veins and minor edema to bilateral lower extremities. Treatment plan recommended by RN included: Treatment - compression hose for vascular issues; Frequency - daily during waking hours; By whom - self and staff. Routine Medications listed on RN Quarterly Assessment dated 7/5/13 included: Ted hose to be worn daily while awake. However, Medication Administration Record dated October 2013 did not reflect this was monitored by facility staff. Observation on 10/28/13 of Resident #1 's feet revealed long toe nails (approximately 1/4 inch) that were protruding from black knit socks. Resident was not wearing compression stockings. Interview with Resident #1 stated his feet hurt yet was unable to explain why they hurt. Interview with Staff D acknowledged Resident #1 takes his compression stockings off. Staff D was unable to describe why resident removes his compression stockings or how often this was monitored by facility staff.	W 339			
W 382	483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to keep all drugs and	W 382	W - 382 Staff H, as well as the rest of the staff, were retrained on medication administration policy and protocol during the staff meeting on 11/5/2013. Going forward there will be at least quarterly medication administration reviews at staff meetings, conducted by the Facility Manager.		

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W 382	<p>Continued From page 20</p> <p>biologicals locked except when being prepared for administration for 1 of 2 expanded sampled residents (Resident #2.) This failure to secure medication placed Residents ' #1, #2, #3, #4, and #5 at risk of potential accidental ingestion of unsecured medications.</p> <p>Findings include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Observation on 10/28/13 at 7:00am revealed Staff H unlocked medication cabinet in medication administration area and administered 1 Cal-gest 500mg to Resident #2. Staff H then left the medication administration area with Resident #2 and State Surveyor unattended in room. Basket containing prescribed medication for Resident #2 and medication cabinet containing other residents ' medication was left open and unsecured. Staff H returned to medication administration area with a spoon.</p> <p>Record review of Camelot Society Medical Policy and Procedures revealed facility staff are responsible for keeping the medication cabinet locked at all times. The cabinet will never be left open and unattended at any time. If staff need to leave during the procedure, the cabinet must be locked.</p> <p>Interview with Staff A and B acknowledged that Staff H should never have left the medication administration area unattended and medication unsecured.</p>	W 382			
W 448	483.470(i)(2)(iv) EVACUATION DRILLS	W 448			

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W 448	Continued From page 21 The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to investigate a problem with an evacuation drill for 3 of 3 sampled residents (Resident #1, #3 and #4) and 2 of 2 expanded sampled residents (Resident #2 and #5). This failure to investigate problems with evacuation drill creates the potential for the problem to be replicated during an actual evacuation and places residents at risk of harm. Findings Include: All record reviews and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated. Record review of the facility 's Fire Drill Log for the 3rd (Night) Shift on 6/27/13 revealed an evacuation time of 12 minutes and 2 seconds. The facility 's Fire Drill Log for the 3rd Shift on 9/27/13 revealed an evacuation time of 1 minute and 15 seconds. Record review of the Fire Drill Logs revealed no explanation of why the 6/27/13 evacuation took 12 minutes and 2 seconds. Interview with Staff A and Staff B revealed they did not know why the 6/27/13 evacuation took 12 minutes and 2 seconds.	W 448	W - 448 Staff will be retrained on Fire Drill documentation to include adding comments if it took the residents over 5 minutes to evacuate the building and to explain why. The Facility Manager will retrain the staff at the December 31 st staff meeting. W - 460 The Facility Manager will schedule a meeting with the nutritionist in order to discuss menu options and examples that reflect the dietary needs of residents that require special dietary guidelines. The staff will then be trained on the dietary needs of each resident, what their special diet consists of, and how to follow those guidelines. Resident #4 is encouraged to make healthy choices when he goes out to eat, however he sometimes chooses less healthy options. Staff cannot force him to make healthy options, as it should be the resident's choice. The Facility Manager will schedule a consultation with the nutritionist by January 6 th , 2014. On-going the nutritionist will be consulted annually or when there is a change or new dietary restriction by the Facility Manager.		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing,	W 460			

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W 460	<p>Continued From page 22 well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to provide specially prescribed diets to 3 of sampled residents (Residents #1, #3 and #4). This failure to provide specially prescribed diets places residents at risk of health problems.</p> <p>Findings include:</p> <p>All observations, record reviews, and interviews were conducted between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Resident #1</p> <p>Observations over a three day period revealed staff often prepared and served meals. Food prepared was not measured to reflect caloric intake recommended.</p> <p>Review of Resident #1 's records revealed RN quarterly assessment dated 7/05/13 and CFA dated 1/10/13 that resident is on a 1500 calorie, high fiber diet.</p> <p>Resident# 3</p> <p>Observation of dietary information for staff posted on the kitchen refrigerator revealed Resident #3 drinks soy milk and has an instant breakfast drink at bedtime but did not reveal any information regarding a high calorie/high iron diet.</p> <p>Observation of lunch meal on 10/27/13 revealed</p>	W 460			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2013
NAME OF PROVIDER OR SUPPLIER BARCLAY GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5027 NORTHEAST 188TH SEATTLE, WA 98155		
(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 460	<p>Continued From page 23</p> <p>Resident #3 and another resident had canned soup for lunch. On 10/28/13 Resident #3 was observed at lunch eating a tuna salad sandwich on wheat bread and a tuna salad, identical to what was served the other residents.</p> <p>Review of Resident #3 ' s records revealed:</p> <ul style="list-style-type: none"> • Physicians Orders Dated 9/21/23 and Registered Nurse Quarterly Assessment dated 8/30/13 revealed resident is to have a high calorie/ high iron daily diet. • CFA dated 9/14/13 revealed in the Medical Nursing section under Gastrointestinal , resident is on a regular diet but did not reveal resident is on a high calorie/high iron diet. • Individual Program Plan dated 9/4/13 revealed an objective that resident will participate in preparing a meal twice a week, but did not mention resident should receive a high calorie/high iron diet. <p>Interview with Staff J revealed she wrote the facility menus but has not written any menus or dietary guidelines for Resident #3 ' s high calorie/high iron diet. Interviews with Staff C, Staff D and Staff E revealed they were not aware that Resident #3 was to receive a high calorie/high iron diet. Interview with Staff C revealed ingredients to make select menu items are not always available.</p> <p>Resident #4 Observation of dietary information for staff posted on the kitchen refrigerator revealed Resident #4 is to have limited fatty foods and no fast foods.</p> <p>Observation of lunch meal on 10/28/13, revealed Resident #4 eating a tuna salad sandwich on</p>	W 460			

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W 460	Continued From page 24 wheat bread and a tuna salad, both of which were mixed using regular (not fat free) mayonnaise. Review of Resident #4 ' s records revealed: • Physicians Orders Dated 9/1/13, Registered Nurse Quarterly Assessment dated 8/30/13 and Annual Nutrition Assessment dated August 11, 2010 revealed resident is to have a regular diet of six small meals a day that follow Gastric Esophageal Reflux (GERD) guidelines to limit fatty foods. • Individual Program Plan dated 9/12/13 revealed an objective that resident will participate in preparing a meal twice a week. The guidelines for this objective revealed the comment that Resident #4 enjoys macaroni and cheese, fettuccine alfredo, polish sausage, bologna sandwiches, and omelets, etc.; all of which are foods high in fat and the guidelines do not mention that Resident #4 should have a regular diet of six small meals a day that follow Gastric Esophageal Reflux (GERD) guidelines to limit fatty foods. Interview with Resident #4 revealed he went out for lunch with staff on 10/27/13 and had pizza. Interview with Staff J revealed she wrote the facility ' s menus but she has not written any menus or dietary guidelines for Resident #4 ' s diet of six small low fat meals a day. Interview with Staff C revealed he was aware that Resident #4 was to avoid citrus. Interviews with Staff C and Staff D revealed they were not aware that Resident #4 was to receive 6 small low-fat meals a day.	W 460			
W 481	483.480(c)(2) MENUS	W 481			

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W 481	<p>Continued From page 25</p> <p>Menus for food actually served must be kept on file for 30 days.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed follow and keep menus of food actually served to 3 of 3 sampled (Resident #1, #3 and #4) and 2 of 2 expanded sampled residents (Resident #2 and #5) on file for 30 days. This failure placed residents at risk of compromised health due to the facility 's inability to identify what food items were served to residents.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were completed between 10/27/13 and 10/29/13, unless otherwise stated.</p> <p>Observations over a three day period revealed staff often prepared and served meals that were not part of the written menu. Observation on 10/27/13 revealed there were 2 oranges in unlocked refrigerator and on 10/28/13 there was no fresh fruit available to residents.</p> <p>Record review revealed a menu book which provided the facility with 12 months of daily menus. The menu substitution list last recording of a substitution was on 7/31/13.</p> <p>Interview with Staff C revealed staff are expected to follow the menus when preparing meals for residents and record menu substitutions. Staff C acknowledged he did not know how to prepare some items listed on the menu, such as French Toast and would substitute with a general staple such as Oatmeal. Staff C revealed the facility did</p>	W 481	<p>W - 481 The facility will keep the list of substituted food items on site for 6 months, and will keep this list in the menu book. The Facility Manager will address this at the staff meeting on December 16th, 2013.</p> <p>The Facility Manager will also look at the menu prior to grocery shopping to ensure that the ingredients or items on the menu are on site. There may be some items that are too expensive for the house to afford. In this case, an alternative item will be purchased that is similar to that on the menu in order to keep the grocery account within budget.</p>		

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

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W 481	<p>Continued From page 26</p> <p>not have the available ingredients to make select menu items. In addition, Staff C was not sure of what week to follow from the menu book.</p> <p>Staff were unable to report what meals had been prepared and served to residents during the past few weeks and did not document meals actually served to residents.</p> <p>Interview of Staff A and Staff B revealed the facility does not have a process in place for keeping on file, a 30 day menu for foods actually served to residents.</p>	W 481		
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STATE OF WASHINGTON
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES
 Residential Care Services
 PO Box 45600, Olympia, WA 98504-5600

Statement of Deficiencies/ Plan of Correction Page 1 of 5	License# 732 Barclay	Completion Date: 10/29/2013
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You are required to be in compliance at all times with all laws and regulations to maintain your boarding home license.

The department has completed data collection for the unannounced on-site inspection on 10/27/2013 thru 10/29/2013 of:

Barclay Group Home
 5027 NE 188th
 Seattle, WA 98155

The following sample was selected for review during the unannounced on-site visit: 3 of 5 residents.

The department staff that inspected/investigated the boarding home:
Claudia Baetge, M.A.
Terry Patton, BSN

From:
 DSHS, Aging and Disability Services Administration
 Residential Care Services
 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.

Linda Bangiel
 Residential Care Services

12/02/2013
 Date

I understand that to maintain a boarding home license I must be in compliance with all of the laws and regulations at all times.

Danny D. Beal
 Administrator (or Representative)

 Date

WAC 388-78A-2480

Tuberculosis-Testing-Required

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Findings include:

All interviews and record reviews were completed between 10/27/2013 and 10/29/2013, unless otherwise indicated.

Interview on 11/13/2013 with Staff B revealed TB testing is conducted two times a month (Monday & Wednesday) and completion of TB testing is dependent upon the facility nurse's schedule. Staff B acknowledged facility expectation that staff have TB test within 3 days of hire and staffs' first day of employment is the date of hire.

Record review revealed seven employees failed to be screened for tuberculosis within three days of employment and began working in the facility prior to tuberculosis screening.

Record review revealed the following:

- Staff A: Date Hired 04/13/10
 Initial TB Test 06/24/13 – 3 years, 2 months, 11 days from date of hire

- Staff B: Date Hired 09/13/12 (on-call)
 Initial TB Test 11/12/12 - 60 days from date of hire

- Staff C: Date Hired 07/01/13
 Initial TB Test 08/26/13 – 56 days from date of hire

- Staff E: Date Hired 09/10/13
 Initial TB Test 10/07/13 - 19 days from date of hire

- Staff F: Date Hired 06/20/13
 Initial TB Test 08/05/13 - 46 days from date of hire

- Staff G: Date Hired 05/07/10
 Initial TB Test 08/26/13 - 27 days from date of hire

- Staff I: Date Hired 06/30/10
 Initial TB Test 07/15/13 - 90 days from date of hire

388-78A-3080 – Guardrails and Handrails

(2) The assisted living facility must install guardrails if the department determines guardrails are necessary for resident safety.

This requirement was not met as evidenced by:

Findings include:

All observations and interviews occurred between 10/27/13 through 10/29/13, unless otherwise noted.

Observation on 10/28/13 revealed that immediately outside the pantry door evacuation exit a steep fall off of up to approximately 10 feet without railing for an area approximately 20 feet wide and 80 feet long between house and the driveway on the east side of the facility. A tree stump with many short sharp branches is located at the steepest area, which was a sheer fall of 3 feet, just after the steps coming from the pantry. The fall then tapered to 1 foot for 4 feet then another sheer fall for 5-6 feet.

There was no guardrail to prevent the residents from falling while they evacuate which creates the potential for harm and injury.

WAC 388-78A-3090 Maintenance and Housekeeping

(1)(b) The assisted living facility must keep exterior grounds, assisted living facility structure and component parts safe, sanitary, and in good repair.

This requirement was not met as evidenced by:

Findings include:

All observations occurred between 10/27/13 through 10/29/13, unless otherwise noted.

Observation of erosion under the cement steps that lead from pantry door to outside, which is an emergency evacuation route, may create a potential for the steps to shift and/or break.

Observation of six large garbage and recycling bins were scattered throughout the emergency evacuation route on the lawn outside the pantry door causing an additional hazard of tripping on or running into these bins.

Observation on a chicken-wire type fence on east side of the facility's back yard had a hole large enough for an individual to bend over and step through. However, a tight strand of barbed wire was across the top of this hole, presenting a hazard to any resident who may attempt to step through the hole in the fence.

Plan of Correction:

Date Completed:

A new company policy has been created that states, all new hires will start their first day of employment on one of our monthly TB test dates unless they can get a TB test done outside of the agency, prior to working directly with clients. This policy was put in place on 10/25/2013 at the Camelot Society's Supervisory Meeting where the facility manager and QIDP attended.

The maintenance supervisor will build a retaining wall to prevent the residents from falling while using that exit. This will be completed by January 6th, 2014.

The maintenance supervisor obtained a second opinion on the steps and it was determined that just the bottom step needs repaired/leveled. The steps will be repaired January 6, 2014.

Because the door is no longer restricted, the bins will now be lined up alongside the house (overseen by the Facility Manager) in order to leave space and room for residents and staff to exit in case of an emergency. The facility manager will check the bins on Wednesdays to ensure that the bins are not scattered throughout the grass. This item will be resolved by December 18th, 2013.

The Facility Manager will do a monthly walk of the exterior of the facility to ensure that there are no health and safety concerns. Any noted issues will be addressed by fixing the issue if possible or submitting a maintenance request.

The maintenance supervisor will remove the barbed wire and will fix the hole in the fence. This will be completed by January 6th, 2014.