

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

PRINTED: 10/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN PARK GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6935 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136</b>
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W 000	INITIAL COMMENTS  This report is a result of an Annual Recertification Survey conducted at Lincoln Park Group Home on 8/19/13, 8/20/13, and 8/21/13. A random sample of 4 residents was selected from a census of 8. An additional 4 residents were included in the expanded sample.  The survey was conducted by:  Claudia Baetge Terry Patton  The survey team is from:  State of Washington Department of Social and Health Services Residential Care Services Administration ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642	W 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">OCT 28 2013</p> <p style="text-align: center;">DSHS-ADSA Residential Care Services ICF/MR Program</p> <p><b>W 108: Fire alarm system not repaired in timely manner after notification of possible failure, and 15 minute fire watch survey not conducted at facility.</b></p> <p>Fire alarm system has been repaired; Lincoln Park Policy One has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign</p>	
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 observation and interview, the facility failed to conduct 15 minute fire watch surveys of the facility as ordered by the Seattle Fire Department. The Seattle Fire Department had ordered 15 minute fire watch surveys due to the	W 108		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>Exec Dir/Administrator</i>	(X6) DATE  <i>10-24-13</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 108	Continued From page 1 fire alarm system ' s failure to notify the fire department directly of a fire. Failure to conduct the 15 minute fire watch survey at the facility puts residents at risk should a fire occur.  Findings include:  All observations, record reviews and interviews occurred between 8/19/13 through 8/21/13.  Review of Seattle Fire Department Notice of Violation dated 7/14/13 revealed the facility needed to repair their fire alarm system and reset their alarm panel. Interviews with Staff C revealed the facility had been notified of false alarms by the fire department since March 2013, but the facility had not had the system repaired by the time of this survey and the fire department could not receive direct notice of a fire at the facility.  During 4 observation periods of more than 30 minutes facility staff were not observed doing the fire watch surveys. Interview of Staff A at 6:00 AM on 8/19/13 revealed she is the only staff working the night shift and she only performed fire watch survey during the beginning and the end of her shift, when staff from other shifts were present.	W 108	responsibility. See attached Lincoln Park Policy One, which bears the effective date of October 14, 2013.	
W 247	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 and interview, facility failed	W 247	<b>W 247: IPP must include opportunities for client choice and self-management.</b>  A menu of substitute foods has been provided that will guarantee an	

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W 247	<p>Continued From page 2</p> <p>to provide food choices and self-management opportunities to 4 of 4 Sample Residents (Residents 1-4) and 4 of 4 Expanded Sample Residents (Residents 5-8) during breakfast. This failure resulted in residents not being allowed to exercise choice and self-management during meals.</p> <p>Findings include:</p> <p>Observation revealed that at 5:40 AM on 8/19/13 the dining room table had place settings for 8 residents. The place settings included flatware, cups, glasses and bowls. One place setting had yogurt in a bowl and another place setting had a small unopened container of yogurt. Glasses at the table contained juice. Two cartons of milk, a large bowl of strawberries and two large plastic containers of dry cereal were on the table. During 8/19/13 interview, Staff A revealed she sets the table for the residents before they get up. Staff A explained she knows what each resident likes to eat and drink and she prepares it for them. Staff A stated the cereal choices were raisin bran or cheerios. Staff A explained that if a resident did not want the cereal or fruit for breakfast the resident could have the meal choice written on a white board in the kitchen. Review of the meal choices on the white board in the kitchen showed the resident 's choices were cereal and fruit, which is what they were having for breakfast.</p> <p>While eating from a bowl of cereal at 7:30 AM Resident #4 revealed she did not have any choice of what she had for breakfast. Resident #4 also revealed that she can help set the table. Review of Resident #4 ' s records revealed she is able to make food choices and provide self-care, including setting the table.</p>	W 247	<p>alternate to the regular menu item; Lincoln Park Policy Two has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Two, which bears the effective date of October 14, 2013.</p>		

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W 261	<p><b>483.440(f)(3) PROGRAM MONITORING &amp; CHANGE</b></p> <p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Human Rights Committee ' s (HRC) membership included at least one member with no ownership or controlling interest in the facility. When the committee approved Special Diets and Psychoactive Medications for 3 of 4 Sample Residents (Residents 1, 3, and 4) and 4 of 4 Expanded Sample Residents ( Residents 5-8) all of the HRC Committee members present were associated with the facility. This failure of having a required specialty constituted committee member who is an impartial outsider violated residents ' rights and protections. Findings include: All record reviews and interviews occurred between 8/19/13 and 8/21/13. Record review revealed that on 8/15/13 the Human Rights Committee reviewed and approved restrictive diet profiles for Residents #1, #3, #4, #5, #6, #7, and #8. No impartial outsider reviewed and approved this plan. Record review revealed that on 8/15/13 the Human Rights Committee reviewed and approved programs for sedating and psychoactive medications for Residents #3, #4,</p>	W 261	<p><b>W 261: Program monitoring &amp; change; no impartial outsider as a member of the Human Rights Committee</b></p> <p>An LPN from another agency has expressed interest, as well as a managing associate at the Kenny Home Lincoln Park Policy Three has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Three, which bears the effective date of October 14, 2013.</p>		

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W 261	Continued From page 4 #5, #7, and #8. No impartial outsider reviewed and approved this plan. Interview with Staff B and Staff C revealed difficulty in finding at least one impartial outsider to participate in the HRC Committee.	W 261			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE  The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.  This STANDARD is not met as evidenced by: Based on record review and interviews, facility failed to ensure the Human Rights Committee (HRC) reviewed, approved and monitored all programs which utilized psychoactive medications for 2 of 4 Sample Residents (Residents 1 and 4) and dietary restrictions for 7 of 8 residents (Residents 2-8). The programs approved by the HRC did not identify the name or class of psychoactive medications. Additionally, the HRC approved dietary restrictions without identifying the nature or type of the dietary restrictions. This failure violated the resident rights and allowed residents to be given unidentified medications to manage behavior, unidentified sedation medications and unidentified dietary restrictions. Findings Include:  All record reviews and interviews were conducted between 8/19/13 and 8/21/13.  Psychoactive Medications:	W 262	<b>W 262: Program monitoring &amp; change; HRC approved psychoactive meds and diet restrictions without full knowledge of what they were approving.</b>  Procedure has been developed to supply written information during HRC meetings; Lincoln Park Policy Three has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Three, which bears the effective date of October 14, 2013.		

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W 262	Continued From page 5 Record review of Physician ' s Orders revealed Resident #1 is prescribed <b>3</b> 150mg to be taken once daily in the evening. On 08/15/2013 the HRC reviewed and approved consent for " psychoactive medication " but did not specify the type of medication. Record review of Physician ' s Orders revealed Resident #4 is prescribed <b>3</b> 200mg to be taken once daily. On 08/15/2013 the HRC reviewed and approved consent for " psychoactive " medication but did not specify the type of medication.  Dietary Restrictions: Record review of HRC consents dated 8-15-13 revealed HRC reviewed and approved restrictions for " diet profile " and consent for " restricted calorie diet " but did not specify the restrictions for Residents #2, #3, #4, #5, #6, #7 and #8. Interview with Staff B and Staff C acknowledged that the consents reviewed and approved by HRC on 8/15/13 did not identify the dietary restrictions and/or medications given to the Residents.	W 262		
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 interviews the facility failed to obtain written consents prior to implementation of restrictive programs that locked the hall closet and laundry room for 4 of 4 sampled residents (Resident ' s	W 263	<b>263: Restrictive Practices without guardian/resident written consent.</b>  Guardian authorizations have been sent and are being returned; Lincoln Park Policy Three has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Three, which bears the effective date of October 14, 2013.	

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W 263	Continued From page 6 #1, 2, 3, and 4) and 4 of 4 expanded sample residents (Resident 's # 5, 6, 7, and 8). This failure denied the residents/guardians the opportunity to make informed decisions about facility restrictive practices and denied residents their right to free access at their residence.  Findings Include:  All observations and interviews occurred between 8/19/13 and 8/21/13.  Observation of facility linen closet containing towels, wash clothes, extra blankets, sheets, and broom were locked. Laundry room and cabinets containing laundry detergent, bleach and a variety of cleaners were locked preventing residents ' access. Interview with Staff E revealed items in the linen closet and laundry room were locked to keep residents safe and residents need to ask staff to get an item the resident needs.	W 263			
W 364	<b>483.460(j)(3) DRUG REGIMEN REVIEW</b>  The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.  This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to ensure that a pharmacist provided a quarterly report for 4 of 4 sample residents (Resident #1, 2, 3, & 4). This failure placed residents at risk for inappropriate medication management and risk for potential medication errors.	W 364	<b>W 364 Drug regimen Review;</b> <b>Pharmacist's Quarterly Reviews not completed (only one review found for last 12 months).</b>  Pharmacist Consultant has been interviewed in respect to this need, and assures reviews will be timely and complete; Lincoln Park Policy Two has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Two, which bears the effective date of October 14, 2013.		

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W 364	<p>Continued From page 7</p> <p>Findings Include:</p> <p>All record reviews and interviews occurred between 8/19/13 and 8/21/13.</p> <p>Record review of physician ' s orders, dated 06/12/13, revealed Resident #1 is prescribed 3</p> <p>3 A review of the past twelve months of Resident #1 ' s medical record revealed the record failed to include any pharmacist quarterly reports that indicated the pharmacist reviewed the medication and discussed any recommendations with the Interdisciplinary Team (IDT).</p> <p>Record review of physician ' s orders, dated 07/2/13, revealed Resident #2 is prescribed 3</p> <p>3 (PRN). Record Review revealed an Individual Program Plan (IPP) report completed by the Clinical Consultant Pharmacist dated 04/03/2013. This report included the pharmacist ' s review of Resident #3 ' s medication regimen and recommended plan. A review of Resident #3 ' s medical record revealed the 04/03/13 report was the only report written by the pharmacist within a twelve month period. The record failed to include any other pharmacist quarterly reports that indicated the pharmacist reviewed the medication and discussed any recommendations with the IDT.</p>	W 364		
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W 364	Continued From page 8 Record review revealed Resident #3 is prescribed <b>3</b> Record Review of Resident #3 ' s medical record revealed an IPP report completed by the Clinical Consultant Pharmacist dated 02/06/13. This report included the pharmacist ' s review of Resident #3 ' s medication regimen and recommended plan. A review Resident #3 ' s medical record revealed the 02/06/13 report was the only report written by the pharmacist within the twelve month period. The record failed to include any pharmacist quarterly reports that indicated the pharmacist reviewed the medication and discussed any recommendations with the IDT. Review of Resident #4 ' s IPP, dated 03/14/13, revealed Resident #4 is prescribed <b>3</b> 200 mg once a day for <b>3</b> Record Review of Resident #4 ' s medical record revealed an IPP report completed by the Clinical Consultant Pharmacist dated 03/12/13. This report included the pharmacist ' s review of Resident #3 ' s medication regimen and recommended plan. A review of Resident #3 ' s medical record revealed the 03/12/13 report was the only report written since Resident #4 moved into the facility on 02/18/13. The record failed to include any pharmacist quarterly reports that indicated the pharmacist reviewed the medication and discussed any recommendations with the IDT. Interview with Staff B acknowledged that a quarterly drug regimen report by a pharmacist was not completed.	W 364			
W 441	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills under varied conditions.	W 441	W 441 Evacuation Drills; Facility must hold evacuation drills under varied conditions (graveyard shift drills)		

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W 441	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, facility failed to ensure evacuation drills on the night shift were conducted under conditions which may actually occur during a fire on that shift. Failure to ensure the evacuation drills are conducted under varied and realistic conditions puts the residents at risk should an emergency occur that necessitates evacuation.</p> <p>Findings include:</p> <p>All record reviews and interviews were conducted between 8/19/13 and 8/21/13.</p> <p>Review of facility Fire Drill records revealed that on 1/8/13 the night shift fire drill was conducted at 6:50 AM. Review of facility Fire Drill records revealed that on 6/6/13 the night shift fire drill was conducted at 9:07 PM.</p> <p>Interview with Staff A revealed day shift staff were present to assist with residents during the 6:50 AM fire drill on 1/8/13. Interview with Staff A revealed that afternoon shift staff were present to assist with residents during the 9:07 PM fire drill on 6/6/13. Interview with Staff A revealed that only one staff may be present on the night shift and other staff would not be present to assist with resident as had occurred during the 1/8/13 and 6/6/13 fire drills.</p>	W 441	<p>A new graveyard fire drill has been implemented; Lincoln Park Policy One has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy One, which bears the effective date of October 14, 2013.</p>	
W 454	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is not met as evidenced by:</p>	W 454	<p><b>W 454 Infection Control; Strong persistent odor of urine in one resident's bathroom.</b></p>	

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W 454	<p>Continued From page 10</p> <p>Based on observations facility failed to provide a sanitary bathroom for 1 of 4 sampled residents (Resident #1) and 1 of 4 expanded sample residents (Resident #6). Failure placed residents at risk of being exposed to unsanitary conditions which could cause health risks.</p> <p>Findings Include:</p> <p>All observations and interviews occurred between 8/19/13 and 8/21/13.</p> <p>Observation of Resident #1 's bedroom and shared bathroom with Resident #6 on 8/19/13, 8/20/13 and 8/21/13 revealed a strong and persistent urine odor.</p> <p>Record review of Resident #1 's Functional Behavior Analysis Report revealed Resident #1 will urinate in his dresser drawers, on the floor, in trashcans, and on his bed linen. If urine was discovered on the floor, in the trashcan, or on bed linen staff were to clean without Resident #1 's knowledge.</p> <p>Record review of QMRP review dated 8/19/13 revealed Resident #1 had no inappropriate urination in in his bedroom in May/June/July 2013.</p> <p>Record review of Resident #1 's Supervision Policy dated 6/01/2013 revealed Resident #1 uses the bathroom independently. Staff needs to monitor for inappropriate urination.</p> <p>Interview with Staff E and F revealed, staff check Resident #1 's room frequently for inappropriate urination. Staff E acknowledged she has never seen Resident #1 urinate in his room and could not explain why strong urine odor persists.</p> <p>Interview with Staff B revealed they have replaced the floor one year ago and panels on bedroom walls two years ago and could not explain why</p>	W 454	<p><del>Stanley Steamer has cleaned several</del></p> <p>carpets and sanitized the bathroom drains, eliminating the odor; Lincoln Park Policy Four has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Four, which bears the effective date of October 14, 2013.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN PARK GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6935 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136</b>		
(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 454	Continued From page 11 strong urine odor persists.	W 454			
W 473	483.480(b)(2)(ii) MEAL SERVICES  Food must be served at appropriate temperature.  This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to maintain appropriate food temperatures and ensure food was served within 15 minutes of being removed from a temperature controlled device. This failure resulted in residents being served food at inappropriate temperatures creating potential for foodborne illness. This failure also denied residents their dignity in being served meals at appropriate temperatures.  Findings include:  Observation revealed that at 5:40 AM on 8/19/13 the dining room table had place settings for 8 residents. One place setting had yogurt in a bowl and another place setting had a small unopened container of yogurt. Glasses at the table contained juice. Two cartons of milk and a large bowl of strawberries were on the table. The temperatures of the beverages and food at 5:50 AM were: Milk 55°F, orange juice 65°F, yogurt 72°F and strawberries 65°F. Staff A revealed the strawberries had been frozen prior to serving. Residents consumed these foods and beverages when they chose to after getting up. Resident #4 at breakfast at 7:30 AM. The milk she used on her cereal and the juice she drank were the milk and juice that had been setting on the table at 5:40 AM. Food must be served within 15 minutes of removal from a temperature controlled device.	W 473	<b>W 473 Meal Services; Foods must be served at appropriate temperature.</b>  Thermometers have been procured, and training and documentation support has been given; Lincoln Park Policy Two has been written to correct damage done to any resident, protect all residents from suffering from harm in similar situations, to monitor and ensure compliance, and to assign responsibility. See attached Lincoln Park Policy Two, which bears the effective date of October 14, 2013.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G040</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LINCOLN PARK GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6935 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136</b>
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W 473	Continued From page 12 Hot foods must be held and served at no less than 140°F in order to destroy bacteria that can cause food borne illness. Cold food items should be held and served at 45°F or cooler.	W 473		
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