

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

PRINTED: 09/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/29/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLN PARK GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 6935 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>This report is a result of an Annual Recertification Survey conducted at Lincoln Park Group Home from 08/26/14 through 08/29/14. The Fundamental Recertification Survey was conducted by observation, documents review and interview. A random sample of four residents was selected from a census of eight residents. The expanded sample included four current residents.</p> <p>The survey was conducted by: Janette Buchanan, RN, BSN Terry Patton, RN, BSN</p> <p>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</p>	W 000	<p>RECEIVED</p> <p>OCT - 9 2014</p> <p>DSHS-ADSA Residential Care Services ICF/MR Program</p>	
W 108	<p>483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS</p> <p>The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to comply with State</p>	W 108		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Exec Dir / Admin</i>	(X6) DATE <i>10-06-14</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	<p>Continued From page 1</p> <p>Regulations (WAC 388-78A-3090) ensuring the evacuation route hallway to exit door on the east side of facility was free from obstructions for 4 of 4 sampled residents (Residents #1, 2, 3 and 4) and 4 of 4 expanded sample residents (Residents #5, 6, 7 and 8). This failure placed residents at risk of injury and/or entrapment in event of an emergency evacuation.</p> <p>Findings include: All observations, records review and interviews were conducted on 08/26/14 through 08/29/14 unless otherwise stated.</p> <p>WAC 388-78A-3090 (1.a.) requires facility to provide a safe environment for residents.</p> <p>Refer to attached statement of deficiencies dated 08/29/14 for details of failed practice under WAC 388-78A-3090</p>	W 108	<p>W108:</p> <p>The mop bucket has not been left in the hallway again. To ensure a continuing safe environment, monitor compliance, and assign responsibility for safety, LP Policy 4: Facility Sanitation and Safety (see attached) has been revised and is effective as of 10-06-14.</p>	10/06/14
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to investigate and determine how a foreign object was found lodged in the esophagus for 1 of 4 sampled residents (Resident #2). This failure resulted in a potential harm from a potential reoccurrence and from not having appropriate preventative measures.</p> <p>Findings include: All observations, interviews and record reviews were conducted at the facility between 08/26/14</p>	W 154	<p>W154:</p> <p>To ensure correct treatment of residents, monitor compliance, and assign responsibility, LP Policy 13: Medical Procedures (see attached) has been created and is effective as of 10-06-14.</p>	10/06/14

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W 154	<p>Continued From page 2 through 08/29/14 unless otherwise stated.</p> <p>Observation of Resident #2 revealed resident was not wearing any jewelry during the week of survey. Facility staff was interviewed regarding resident wearing necklaces or bracelets. Staff stated that due to resident having the bead found in his throat during his routine [redacted] injection for increasing difficulty with swallowing secondary to a diagnosis of [redacted] he no longer wears beaded necklaces or bracelets.</p> <p>Review of Resident #2 ' s record on 08/27/14 revealed Resident requires a Mechanical Soft diet low in carbohydrates with no concentrated sugars due to a condition affecting his [redacted] which can prevent him from swallowing. Resident #2 had gone into the hospital on 10/15/13 for a scheduled procedure for [redacted] involving scoping Resident #2 ' s [redacted] and [redacted] injections to improve his swallowing. During scoping the physician found and removed a bead lodged in the middle third of Resident #2 ' s esophagus. The physician did not report any injury occurred to Resident #2 as a result of the bead being lodged in his esophagus and informed the facility on 10/16/13 by e-mail the foreign object was a light blue bead used to make necklaces.</p> <p>Review of Resident ' s #2 ' s Supervision Policy, revised December 2013 (2 months after the physician found the bead lodged in Resident #2 ' s [redacted] revealed staff were to monitor the amount and type of jewelry Resident#2 wore.</p> <p>Interview with Staff A on 08/27/14 revealed he was unaware an Incident Report was not completed. Staff A stated he was unaware why an</p>	W 154		

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W 154 Continued From page 3
investigation had not been completed by the previous Health Services Manager. No facility staff determined how the blue bead had gotten lodged in Resident #2 ' s [REDACTED] or how long that it may have been there. When interviewed, Staff A and C stated Resident #2 wore bracelets and necklaces with beads on them and that he liked to chew on them.

W 252 Interview with Resident #2 ' s sister via telephone on 08/28/14 revealed she was aware of the incident on 10/15/13 and had given instructions for Resident #2 to not have beads anymore due to this incident.

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:
Observation during on-site visits during the week of 08/26/14 through 08/29/14 revealed all meal preparations were done by facility staff.

Review of Resident #2's monthly data collection sheet for July and August 2014 revealed resident has a Cooking program. The Cooking program requires Staff to provide Resident #2 with 1:1 supervision during all aspects of the Cooking program due to dangers presented by utilizing the kitchen and needing to ensure the prepared food is soft-mechanical, following Resident #2's diet. Review of documentation on 08/27/14 revealed there is no data regarding Resident #2's cooking

W 154

W252:

W 252 Lincoln Park Group Home had self-assessed the need for improved program completion and charting prior to the arrival of the survey team. The results have been improved completion and charting. Now, **LP Policy 14: Program Completion and Charting; Responsibility Breakdown** has been created to formalize effective changes. Already in practice, this policy is effective 9-25-14.

09/25/14

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W 252	Continued From page 4 program for either July or August 2014. Staff A stated he was unaware Resident #2 was not doing his cooking program. Facility staff revealed they follow resident programs listed in the facility computer program (Therap) to determine which programs residents are to receive and how often.	W 252		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to, at least annually, update the Comprehensive Functional Assessment (CFA) for 3 of 4 sampled residents (Resident #1, 2, and 4). Failure to review and revise the residents' CFAs placed residents at risk of having unmet needs, loss of life skills and loss of independence due to staff ' s inability to identify current residents' needs and to help residents meet their needs. Findings include: All interviews and record reviews were conducted at the facility between 08/26/14 through 08/29/14 unless otherwise stated. Residents' Individual Program Plans (IPP) and Positive Behavior Support Plans (PBSP) are, at least annually, to be reviewed and modified based on information in the residents' current CFA.	W 259	W259: LP is getting a new QIDP (start date is 10-08-14) and a new Behavior Consultant, Tore Lydersen, began his consult with LP in late September. They will be tasked to produce CFAs as soon as possible, but an extension will be required, as the 45 th day following the last day of the survey is October 13. LP Policy 14: Program Completion and Charting; Responsibility Breakdown contains requirements and remedies for this duty to be performed.	10/27/14

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W 259	Continued From page 5 Resident #1 Review of Resident #1's records reveal she had a CFA completed on 11/01/12. No CFA had been completed for Resident #1 since 11/01/12. Resident #2 Review of Resident #2's records revealed he had a CFA completed on 03/14/13. No CFA had been completed for Resident #2 since 03/14/13. Resident #4 Review of Resident #4's Comprehensive Functional Assessment was completed on 01/15/13. No CFA had been completed for Resident #4 since 01/15/13. Interview with Staff A on 08/28/14 revealed he is aware the CFA's and PBSP's for Residents #1, 2, and 4. Staff A reported the facility does not currently have a person to write the CFA's and PBSP's. They are attempting to hire someone to write the CFAs and PBSPs.	W 259		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a pharmacist provided thorough reviews of drug regimens for 4 of 4 sampled residents (Resident #1, 2, 3, and 4)	W 362		

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W 362	<p>Continued From page 6 during the quarterly review process. This failure placed residents at risk of inappropriate medication management and potential medication errors.</p> <p>Findings include:</p> <p>All interviews and record reviews were conducted at the facility between 08/26/14 through 08/29/14 unless otherwise stated.</p> <p>Review of health care records for Residents #1, 2, 3 and 4 revealed facility had quarterly reports from a pharmacist identifying what medications each resident was taking. The quarterly pharmacist reports did not provide information pertaining to the response of the residents to their drug regimens.</p> <p>Interview with Staff A revealed the pharmacist summarizes the residents' responses to their drug regimen only once a year.</p>	W 362	<p>W362:</p> <p>LP Policy 3: Human Rights Committee and Medication Regimen Reviews has been revised, and another form has been created, to ensure a complete med review at least quarterly for each resident. This revision is effective today, but the next Medication Regimen Review, previously scheduled for October 16, 2014, will be postponed because the pharmacist has informed us he will be unable to attend on that day. The pharmacist consultant will be sent the paperwork he needs to assist him to finish the reviews by October 13, but it is unknown whether he will succeed by that date.</p>	10/13/14
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review, and interview, the facility failed to administer medication to 1 of 4 sampled residents (Resident #2) as prescribed without error. This failure could cause Resident #2 to have bowel discomfort.</p> <p>Findings include:</p>	W 369	<p>W369:</p> <p>Staff Member B has been retrained on the Five Rights of Medication Administration, with emphasis placed on the fact that the Five Rights must be fully verified three times with each Medication Administration. As an added precaution, all LP staff will be retrained and will re-review the Five Rights of Medication Administration.</p>	09/01/14 10/13/14

Back
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W 369	<p>Continued From page 7</p> <p>All observations, record review and interview were conducted at the facility between 08/26/14 through 08/29/14 unless otherwise stated. Review of Resident #2's record revealed he has an order for [REDACTED] 30 ml that is to be given Monday, Wednesday, and Friday at 6:00 PM. [REDACTED] is a used to treat constipation. It usually is taken once a day for treatment of constipation and is to be taken exactly as directed. [REDACTED] could cause side effects such as diarrhea, gas, nausea, stomach pains, cramps, and/or vomiting.</p> <p>Observation of Resident #2's medication self-administration, with assistance by Staff B, on 08/27/14 at 8:25 AM revealed Resident #2 received [REDACTED] Dosage and resident were correct, however time was incorrect. The [REDACTED] as ordered by the physician, should not have been given until 6:00 PM on 08/27/14.</p> <p>Interview with Staff B revealed he normally works evenings and saw the medication was one time a day on Monday, Wednesday, and Friday and knew it was the right day, so he gave it. Staff B stated he was very nervous and misread the times the medication was to be given.</p>	W 369		