

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

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

8837

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D 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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an Annual Recertification Survey conducted at Fircrest School PAT A from 04/13/13 through 04/17/13. A sample of 12 residents was selected from a census of 124. The expanded sample included 57 current residents.</p> <p>The survey was conducted by  B.A.  R.N., B.A.  R.N., B.A.  M.A.</p> <p>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</p> <p>Telephone: (360) 725-2405 Fax: (360) 725-2642</p>	W 000	<p>W104 – All staff on units 301-302, 311-312, 313, 317 and 319-320 have been retrained in the proper labeling and storage of food items on unit: All food items must be labeled with open/received date and disposal date. All opened items must be stored in airtight containers. Airtight storage containers and Ziploc bags have been made available in the Fircrest commissary for easy ordering. ACMs will make twice-weekly inspections of all food storage locations to ensure compliance. All unlabeled or improperly stored foods will be discarded upon discovery. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure proper food handling and storage and failed to provide a well repaired and hazard-free environment in 8 of 18 Units. Failure to store and handle food properly placed residents at risk of foodborne illness and failure to</p>	W 104	<p>W104 – All AC staff in PAT A have been retrained in the proper labeling and storage of food items on unit: All food items must be labeled with open/received date and disposal date. All opened items must be stored in airtight containers. Airtight storage containers and Ziploc bags have been</p>	

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

Brad Benoit

TITLE

Asst Supt.

(X6) DATE

5/29/13

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 104	<p>Continued From page 1 provide a well repaired and maintained environment placed residents at risk for harm and injury.</p> <p>Findings include:</p> <p>All observations and interviews were between 4/13/13 and 4/17/13 unless otherwise stated.</p> <p>Observations of kitchens were not completed on all units.</p> <p>Observations of Unit kitchens, Main kitchen and other storage units revealed, but were not limited to, the following:</p> <p>Unit Kitchens and Pantry Areas</p> <p>Kitchen refrigerators, freezers, cupboards and pantry areas of Unit 301, 302, 311, 312, 313, 317, 319, and 320 contained food items that were past the expiration dates and contained food items that were opened, unlabeled and undated.</p> <p>Facility Main Kitchen</p> <p>Kitchen cooking area</p> <ol style="list-style-type: none"> Variety of spices, no open date Metal pitcher with unknown substance Canola oil, no open date Basket with misc. items and cooking utensils: 3/4 measuring cup, 1/3 measuring cup, black clips, wound wipes, alcohol prep., post-its <p>Main Walk-in Freezer</p>	W 104	<p>airtight containers. Airtight storage containers and Ziploc bags have been made available in the Fircrest commissary for easy ordering. ACMs will make twice-weekly inspections of all food storage locations to ensure compliance. All unlabeled or improperly stored foods will be discarded upon discovery. AC staff have signed training forms on this issue.</p> <p>COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A – AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p> <p>W104 – Fircrest Main Kitchen will ensure food is handled properly, to ensure the health and safety of the clients and to keep clients safe from food borne illness by:</p> <ul style="list-style-type: none"> Re-In service dietary staff on food guidelines regarding closing and storage of open food, labeling and dating. Food Service employees have been directed to initial food items when labeling and dating food to assist with accountability. Cook 3 will do an environmental check list at the beginning of each day. 		

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W 104	<p>Continued From page 2</p> <ol style="list-style-type: none"> Sorbet, expired 3/2/13 Pork sausage patties, (labeled pureed) in box, exposed to air, no open date Dinner rolls (3), no open date Whole wheat hot dog buns (5), no open date Cakes on large tin pan (2), partially exposed to air, unlabeled, no date Pizza (3), no open date Bag of blueberries, no open date Cupcakes in Ziploc bag (5), unlabeled, no open date Chicken in Ziploc bag, unlabeled, no open date Turkey meat in box covered with plastic wrap, exposed to air, freezer burn, no open date Boneless ribbed shaped patties, exposed to air, freezer burn, no open date Meat (?), exposed to air, freezer burn, no open date Sausage links, box (2), exposed to air, no open date <p>Storage area</p> <ol style="list-style-type: none"> Bottle with prescription medication (belonging to staff person) on storage shelf Tasteeos cereal (14 bags), expired 10/24/12 <p>Pantry (walk-in)</p> <ol style="list-style-type: none"> Real Mayo, 16.5 oz, no open date Caesar Dressing (1 gallon), no open date Pourable Blue Cheese, no open date Milk (2 gallons), expired 4/9/13 <p>Refrigerated Unit</p> <ol style="list-style-type: none"> Coffee Mate Creamer, no open date International Delight coffee creamer, no open date 	W 104	<ul style="list-style-type: none"> Food service supervisor will do environmental check list at the end of each day. Environmental check lists will be turned into Food Service Manager each day. Food Service Manager will monitor by doing a walk through each morning upon arrival to ensure food is stored properly. Main Walk-in Freezer has been cleaned and organized. All food in freezer improperly sealed or out dated has been discarded. Food Service Manager will update the procedure on Pulling Food from Freezer, adding an inventory component pulling the older dated food forward upon arrival of the new food order. Cook 3, Cook 2, Morning Cook and Food Service supervisors and warehouse worker will be in-serviced on updated procedure. <p>COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Elisabeth Thompson, Food Services Manager Brad Benoit, Assistant Superintendent</p> <p>W104 -Warehouse employee was reassigned to commissary when Prescription medication was found on</p>	

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W 104	<p>Continued From page 3</p> <p>Upright Freezer</p> <ol style="list-style-type: none"> Pizza in Ziploc bag, unlabeled, no open date Hamburger patties, unlabeled, no open date Bag of French fries, no open date Bag of tater tots, no open date Bag of chicken breasts, no open date Individual portions of rice (2), no open date 1 gallon barbeque sauce, spilled over sides <p>Unit Bathrooms</p> <p>Bathrooms in Units 303, 304, 308, 313, and 319 had no toilet paper available to residents.</p> <p>Bathrooms in Units 311, 314, 316 and 320 had toilet paper out of reach for residents that were either placed on the windowsill, on bathroom counter or in bathroom drawer.</p> <p>Bathrooms in unit 317 had toilet paper locked in cabinet and not accessible by residents.</p> <p>Laundry</p> <ol style="list-style-type: none"> Unit 305- Clean laundry was placed on the floor outside residents ' rooms. Unit 317/318- Six stacks of clean clothing were on the floor in the laundry room. Unit 320- A pair of damp black TED hose had been placed on the floor HVAC vents. Staff revealed the TED hose had been washed by hand and were laying on the floor vents to dry. <p>Interior/Exterior</p>	W 104	<p>shelf in storeroom near food. The warehouse employee is supervised by CIBS not Fircrest. CIBS Management completed an investigation of the incident and will be addressing the matter via performance feedback with the employee.</p> <p>COMPLETION DATE: 5/31/13</p> <p>PERSON(S) RESPONSIBLE: Jena Richmond, CIBS Procurement/Supply Manager Brad Benoit, Assistant Superintendent</p> <p>W104 – (Unit bathrooms) ACM's have given documented expectations to AC staff that they are to ensure that toilet paper is always available in the bathroom. AC staff have signed training forms on this issue.</p> <p>COMPLETION DATE: 5/31/13</p> <p>PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent</p> <p>W104 – (Laundry) ACM's have given documented expectations to AC staff that they no laundry is to be stored on the floor or dried on floor vents. Staff will put laundry away properly. Each shift</p>	

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W 104	Continued From page 4 Interior Units 1. Unit 301- Missing handles on cabinet in dining area 2. Unit 302- Burned out bathroom light 3. Unit 302- Wall tile was hanging off the wall between rooms 13A and 13B. 4. Unit 306- The toilet in bathroom #10 had water leaking from the base, creating a small puddle on the floor. 5. Unit 320- A plastic tub had been placed in the middle of the living area to catch water from a leak in the ceiling. The leak had not been reported to the maintenance department. 6. Unit 320- Water was leaking through the vent above the toilet in bathroom #10. Exterior Units Bags containing dirty laundry had been placed in the outside storage containers designated to hold the dirty laundry on Units 302, 303/304, 311/312, 313/314 and 317/318. The storage units did not have the capacity to hold the volume of laundry causing the container doors to not stay closed. It was observed that over the period of several days the laundry bags fell out of the storage containers and remained scattered on the ground near the entrance of the units. Used food trays from the main kitchen, one still containing food, had been left outside for several hours near the entrance to Unit 317/318.	W 104	charge will check to ensure that laundry is stored properly. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent W104 – (Interior Units) ACM's have completed work orders for the following repairs to be done: • 301 –missing handles in dining area • 302 – burned out bathroom light • 302 – wall tile hanging off wall between Rooms 13A & 13B • 306 – the toilet in bathroom #10 leaking near base • 320 – roof leak • 320 – water leaking through the vent in Bathroom #10 COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent W104 – Each ACM will review the procedure and form to get maintenance repairs done in the home with all AC staff. AC staff will be instructed to complete these forms when they observe something which needs to be fixed, repaired.		
W 116	483.410(c)(6) CLIENT RECORDS The facility must provide each identified residential living unit with appropriate aspects of	W 116	COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent		

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W 116	<p>Continued From page 5 each client's record.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff had access to the most current and relevant information for 5 of 12 sampled residents (Resident #3, 5, 7, 8 and 11) and 3 of 57 expanded sample residents (Resident #31, 36 and 41). Failure caused staff to be unaware of a residents' functioning level, medical issues, restrictive practices and dietary needs.</p> <p>Findings Include:</p> <p>All record reviews and interviews were completed between 4/13/13 and 4/17/13 unless otherwise stated.</p> <p>The PBSB 's found in Resident #5, 7, 8, and 11 medical/behavioral charts were outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors.</p> <p>The CFA/IHP found in Resident #41 's chart was outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors.</p> <p>The PBSB 's found in Resident #3, 8, 11 and 36</p>	W 116	<p>W104 – (Exterior units) The outside plastic storage units designated to hold dirty laundry have been determined to be inadequate for the purposes of holding dirty laundry. Each home on PAT A will receive a new, more robust, and sturdier storage container for dirty laundry. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent</p> <p>W104 – (Exterior units) ACM's have given documented expectations to AC staff that when/if food trays are outside the home the trays will be clean and clear of all food. Each shift charge will be responsible for making sure that the exterior of the home is sanitary. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A ACM's Brad Benoit, Assistant Superintendent</p> <p>W116 – (Client Records) SOP I.B.06 (Role of ID Team) clearly indicates that it is the HPA's role to keep the client's chart current. Each HPA will review this SOP and review these expectations with their supervisor. HPAs will ensure each client chart is current. COMPLETION DATE: 5/31/13</p>	

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W 116	Continued From page 6 program charts were outdated. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. The IHP found in Resident #5 's program chart was outdated and from a previous facility. The updated CFA/IHP had not been filed in program book. The current Staff Guidelines were not found in Resident #31 's program book. When the facility was asked to produce updated copies they were able to print out the documents and provide them to the state surveyors. Interviews with facility staff revealed Program Books are used by direct care staff to identify any resident information including dietary needs, restrictive interventions, and program plans. Staff are expected to document program data in the program book. Staff interviews revealed staff ask co-workers for resident information when program books are not up to date.	W 116	PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent W116 – (Client Records) Each ID Team has been instructed to review all client's charts/program books to ensure that each record contains all the most recent versions of treatment plans (CFA/IHP/PBSP/Profiles/Staff Instructions/Training Programs). COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by:	W 148	W148 – (Communication) HPAs will review existing consents and note for which situations parents/guardians want notification. Parents/guardians will be notified according to their preference. HPA's are responsible for all non-medical notifications according to preferences the guardian has identified on the consents. HPA's will review this expectation with their supervisor. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1		

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W 148	<p>Continued From page 7</p> <p>Based on record review and interviews, facility failed to notify parents/legal guardians for 2 of 12 residents (Resident #3 and #10) regarding significant events involving harmful behaviors and use of psychotropic medications. Failure prevented parents/guardian from receiving immediate knowledge of significant incidents which may impact resident ' s physical health and safety.</p> <p>Findings include:</p> <p>All record reviews and interviews were completed between 4/13/13 and 4/17/13 unless otherwise stated.</p> <p>Interview with Resident #3 ' s parent/guardian revealed that parent had not been notified when resident: received STAT medications on 03/15/13, was placed in physical restraints on 03/15/13, 03/24/13 (x2), and had exhibited recent behavioral episodes on 03/24/13. Resident #3 ' s parent signed Consent and Service agreement stating he wanted to be informed of all incidents that occurred with resident.</p> <p>Review of Resident #10 ' s records revealed Resident #10 parent/guardian had not been notified when resident received 1 milligram [REDACTED] by mouth at 4:00 PM and again at 7:45 PM on 04/12/13. Nursing notes revealed [REDACTED] was given for resident ' s agitated behavior. Resident #10 ' s documentation revealed guardian had not given consent for [REDACTED] (or related drug) for behavioral control. Consent and Service</p>	W 148	<p>Brad Benoit, Assistant Superintendent</p> <p>W148 – (Communication) According to SOP I.B.06 (Role of Interdisciplinary Team), the Health Care Coordinator is the designated person with the primary role to: <i>“Inform guardians of accidents that result in injuries that have the potential for requiring physician intervention, such as falls, significant changes in client condition, need to alter treatment significantly, or commence a new treatment. Communicates appointments as requested by the guardians and documents guardian conversations/notifications in the Health Care Notes.”</i> Thus, all Health Care Coordinators will review SOP# I.B.06 and be instructed by their supervisor to follow this procedure with specific emphasis placed on guardian notifications. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Frankie Jackson, RN 4</p> <p>W148 – (Communication) SOP I.A.07 (Psychoactive Drug Usage) - Nursing</p>

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W 148	Continued From page 8	W 148	Procedure I.I.5 will be modified to ensure that in instances of emergency use of psychoactive medications: " <i>The nurse administering the medication will notify the client's guardian of the medication given, the reason the medication was given and the client's response and condition after the medication was given.</i> " All nursing staff will be in-serviced on this change in nursing procedures.		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and records review, the facility failed to appropriately assess, update and make relevant Positive Behavioral Support Plans (PBSP) for 1 of 12 sampled residents (Resident #3) and 1 of 57 expanded sampled residents (Resident #13) in relation to the resident 's behavioral management needs. This failure placed residents at risk of harm due to staff 's inability to implement necessary supervision and protection. Findings include: All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13. Observations, interviews and record review revealed conflicting information regarding the supervision of Resident #3. Resident #3 's program book revealed a PBSP, dated 10/16/12, which stated supervision of Resident #3 should be two staff for one resident (2:1). In the same program book the Directions to Staff, dated 09/27/12, stated supervision would be one staff for one resident (1:1) Resident #3 's Personal Profile state supervision would be one staff to three residents (1:3).	W 214	COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Frankie Jackson, RN 4 W214 - HPA's (with assistance from the rest of the ID Team) will check all Personal Profiles to ensure all are updated and current. Once personal profiles are considered current, AC staff will be trained on Personal Profiles. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent W214 - IDT (lead by HPA) will review all people receiving enhanced supports (i.e. 1:1, 2:1, etc.) to ensure that the most current established supervision requirements are characterized		

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W 214	<p>Continued From page 9</p> <p>Observation of Resident #3 revealed no staff providing direct supervision. Resident was sitting in a lounge chair talking with State Surveyors as staff assisted other residents.</p> <p>Interview of HPA revealed Resident #3 was 1:2 (one staff for 2 residents) and had not been 2:1 or 1:1 for a long period of time. During the state survey the unit psychologist added hand written notes to the Directions For Staff section of Avoidance Procedures and stated the resident does not have one-to-one supervision, never the less, implement all the instructions under one-to-one supervision.</p> <p>HPA and psychologist agreed that the by failing to update PBSP, Directions to Staff, and the Personal Profile staff would have difficulty knowing how to care for the resident.</p> <p>Observation on 4/13/13 (night shift) revealed no staff were within line of sight of Resident #13 but one staff may have been within hearing distance. On 4/13/13 (day shift) a staff was observed staying within arm length of Resident #13. On 4/14 /13 (evening shift) staff were observed keeping Resident #13 within line of sight.</p> <p>Record review of Resident #13 revealed several documents with conflicting information. Positive Behavior Support Plan (PBSP) section, a document dated 2/2/11 " Guidelines for the two staff required to work with Resident #13 " identified in all locations two staff must be with Resident #13 (2:1 monitoring ratio) and one of those staff must be within arm length of Resident #13 to prevent her from harming herself. The</p>	W 214	<p>consistently throughout each care plan. The IDT will also review the 1:1 supervision instructions for AC staff to ensure that they are clear, specific, and lack ambiguity. Once it is assured that the 1:1 supervision requirements are clear/specific and consistently documented across all care plans, the</p> <p>IDT will train all AC staff assigned to the home on the supervision requirements. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent</p> <p>W214 –All PBSPs, PBSP Staff Instructions will all consistently reflect the appropriate level of supervision that is necessary to keep the individual and others safe in various environments. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist</p>		

Brad Benoit 5/29/13

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W 214	Continued From page 10 same section of Resident #13 's record revealed a PBSP dated 12/15/11 which had one staff monitoring Resident #13 (1:1 ratio). The PBSP noted that if a 1:1 staff is scheduled the staff will be near Resident #13 at all times and work only with Resident #13. The PBSP found in Resident #13 's program Book, which is used by staff to record data pertaining to Resident #13 's program, was dated 12/8/10. Interview with staff revealed inconsistencies in their understanding of Resident #13 's plan to protect Resident #13. A night shift supervisor revealed 1 staff could monitor up to 3 residents (1:3 staff to residents), including Resident #13, within hearing on the night shift. A day shift supervisor revealed she believed 1 staff had to stay within arm length of Resident #13 at all times. The Unit 's supervisor revealed staff needed to keep Resident #13 within line of sight.	W 214			
W 251	483.440(d)(3) PROGRAM IMPLEMENTATION Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the Positive Behavioral Support Plan and implement appropriate supervision for 1 of 57 expanded sample residents (Resident #17). This failure placed resident at risk for unmet medical and	W 251	W251 – IDT (lead by HPA) will review all people on PAT A receiving enhanced supports (i.e. 1:1, 2:1, etc.) to ensure that the most current established supervision requirements are characterized consistently throughout each care plan. The IDT will also review the 1:1 supervision instructions for AC staff to ensure that they are clear, specific, and lack ambiguity. Once it is assured that the 1:1 supervision requirements are clear/specific and consistently documented across all care plans, the IDT will train all AC staff assigned to the home on the supervision requirements. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE:		

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W 251	Continued From page 11 care needs. Findings include: On 04/13/13 at 4:34 a.m. observation of Resident #17 asleep in bed in his room, his bedroom door pulled shut. Further observation revealed two staff on night shift; one sitting on couch in living room area and second staff walking down the hallway connecting Unit 312 and 311. On interview, the two staff revealed Resident #17 was on enhanced supervision due to behavioral concerns. They reported that supervision could be provided while positioned in the living room. Review of Resident #17 ' s PBSP revealed a staffing ration of 1:1 and directions for night shift included visual supervision to monitor for [REDACTED] activity. Resident #17 has a [REDACTED] r and a Vagus Nerve Stimulator (VNS) implanted to assist in the management of his [REDACTED] activity. VNS is used to prevent [REDACTED] by sending regular, mild pulses of electrical energy to the brain via the [REDACTED] nerve. If the regular interval electrical pulses do not prevent a [REDACTED], a magnetic wand can be used to deliver an extra pulse of stimulation. This extra electrical stimulation can stop the [REDACTED], shorten the [REDACTED] or reduce the [REDACTED] severity. The unit Attendant Counselor 3 reviewed the PBSP and reported resident ' s door should be left open and staff should be positioned outside of the door and have the resident within their line of sight, during the night shift. Observation at 4:34 a.m. on 04/13/13 revealed the door was not left open and staff were not positioned to provide the necessary line of sight supervision of the resident.	W 251	Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262	W262 – Resident # 13 will have the addition of Lorazepam reviewed by the Human Rights Committee. Resident #31 will have the addition of Oxcarbazepine reviewed by the Human Rights Committee. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Chang, Chief Psychologist W262 – The IDT will cross-check all psychotropic medications given with consents/HRC approvals of PBSP Medication plans to ensure that each psychotropic medication currently being administered has received the proper		

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W 262	<p>Continued From page 12</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews facility failed to ensure the Human Rights Committee (HRC) reviewed, approved, and monitored all programs which utilized restrictive techniques for 2 of 57 expanded sample residents (Resident #13 & 31). This failure allowed resident to be given medications to manage behavior before HRC had given consent and has violated the rights of these Residents.</p> <p>Findings include:</p> <p>Resident #13:</p> <p>Records review on 4/13/13 revealed [REDACTED] (a [REDACTED] medication that affects behavior) 1 mg twice a day was ordered by a physician to start on 8/2/12. Review of the Medication Administration Records revealed Resident #13 has received [REDACTED] 1 mg. as prescribed, since 08/2/12. Interview on 4/15/13 with the facility's supervising Psychologist revealed the [REDACTED] Rights Committee had not approved a program for Resident #13 using [REDACTED] as ordered or any similar medication.</p> <p>Resident #31:</p> <p>Records review on 4/15/15 revealed a 2/13/13 physician order for [REDACTED] (a</p>	W 262	<p>guardian consent and HRC review/approval. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA 1 Brad Chang, Chief Psychologist Brad Benoit, Assistant Superintendent</p> <p>W262 - Medical providers, Pharmacy staff, HCC's, HPA's, Psych's, QA staff will be in-serviced on the following protocol related to psychoactive medication:</p> <ul style="list-style-type: none"> • For all new psychoactive medication prescriptions: <ol style="list-style-type: none"> 1. Medical providers will assist IDT with justifications for the start of a new psychoactive medication. 2. The IDT will present the justifications for the medication and seek consent (30 day emergency telephone consent) from the guardian. QA Department will contact the Chair of the HRC for emergency approval for the use of the new psychoactive medication. 3. The QA Department will notify Pharmacy when the guardian's emergency consent and the emergency HRC Chair's approval have occurred for the medication. 4. Upon this notification from QA, the Pharmacy will dispense the psychotropic medication prescription. 5. The medication plan, which is an Addendum to the PBSP, and an updated 	

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W 262	Continued From page 13 psychoactive medication that effects behavior) 300 mg by mouth twice a day for 1 week then, after the first week, increased to [REDACTED] 600 mg. by mouth two times daily. Review of the Medication Administration Records revealed Resident #31 has received the [REDACTED] as prescribed, since 2/12/13. Interview on 4/16/17 with the Habilitation Plan Administrator revealed the Human Rights Committee has not approved a program for Resident #31 using [REDACTED] or any similar medication.	W 262	written informed consent, will be presented to the HRC for review/approval. The PBSP-Medication Plan Addendum and the Informed Consent will be sent to the guardians for their approval and consent. • For <u>current</u> psychotropic medications: 1. QA Department will provide Pharmacy with current consents for medication labels. 2. Pharmacy will publish a 30-day notice when consents are due to expire as a tickler to the IDT for tracking purposes. 3. All labels for psychoactive medications will display the expiration date for the consent for the current prescription. COMPLETION DATE: 6/14/13		
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 observations, record reviews, and interviews facility failed to obtain written consents prior to implementation of restrictive programs in regards to locking resident bedroom doors, locking grooming/hygiene items and locking sharp knives/items, in 5 of 18 units. Failure to obtain written consents denied the resident/guardian the opportunity to make informed decisions about facility restrictive programs. Findings include: All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13. Unit 311 Resident #5 and #24 bedroom doors were locked and residents were unable to enter	W 263	PERSON(S) RESPONSIBLE: Frankie Jackson, RN 4 Debbie Kruse, DDA 1 Brad Chang, Chief Psychologist Lura Dunn, QA Director Brad Benoit, Assistant Superintendent Asha Singh, Medical Superintendent W262 –HPA's and Psych staff will review and sign an in-service form on SOP I.A.07 (Psychoactive Drug Usage), which specifically addresses consents and HRC approval requirements for the use of psychoactive drugs (Section: Use of		

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W 263	Continued From page 14 their rooms without asking staff for assistance. Unit 312 Resident #6, #14, and #18 bedroom doors were locked and residents were unable to enter their rooms without asking staff for assistance. Unit 313 Resident #7, 19, 20, 21, and 23 grooming/hygiene items were locked in bathroom cabinets. Residents were unable to access items without asking staff for assistance. Units 317/318 Sharp knives were in plastic container sitting on shelf upstairs. The door leading to the stairs was locked, preventing residents from accessing the items. Interviews and document review revealed written consents had not been obtained prior to implementing these restrictive programs.	W 263	Psychoactive Medications – Subsection B). COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist Debbie Kruse, DDA 1 W263 – (Program Monitoring & Change) Each HPA on PAT A will review SOP I.A.03.1 (Informed Consent) with their supervisor, be instructed to follow the SOP, and sign an in-service form. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 Brad Benoit, Assistant Superintendent	
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on interview and records review, facility failed to identify and document systematic use of positive alternatives and effectiveness of alternatives, prior to using restrictive techniques (██████████ medications) for 2 of 12 Residents (Resident #3 and 10). Failure denied residents the opportunity to be provided less intrusive restrictive techniques to manage their behavior.	W 278	W263 – (Program Monitoring & Change) IDT will assess each client's need for restrictive devices and interventions. Written consent from client's parent/guardian will be obtained by the HPA for approval of all restrictive devices or interventions recommended by the IDT. Direct care staff will be trained on implementation of restrictive devices/interventions and sign an in-service form to document the training. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Debbie Kruse, DDA1 W278 – The PBSPs for Client # 3 and Client # 10 will be reviewed by the treating psychologist to ensure that there are proactive positive behavioral	

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W 278	Continued From page 15 Record review and interviews revealed Resident #3 had no evidence that resident received the least restrictive restraint technique for his behavioral control. There is no documentation to reflect resident ' s PBSP had been followed to control his behavior. Record review and interviews revealed Resident #10 had no evidence that resident received the least restrictive interventions for his behavioral control. Nursing records revealed [REDACTED] was given for Resident ' s agitated behavior. Resident #10 ' s PBSP showed 4 interventions which should be used to address challenging behaviors. There was no documentation as to whether these least restrictive techniques were attempted or effective prior to Resident #10 receiving [REDACTED].	W 278	strategies to be implemented in order to avoid the occurrence of challenging behaviors. When challenging behaviors are manifested, the PBSP will provide specific positive intervention strategies progressing from the least intrusive to the most restrictive techniques to be used to keep the individual and others safe from harm or injury. Staff members will be trained by the treating psychologist for Client # 3 and Client # 10 in their PBSP and how to implement positive behavioral strategies and techniques from the least intrusive to the most restrictive interventions for these individuals. Staff members will also be trained to document their positive behavioral support interventions from the least intrusive to the most restrictive on Client # 3 and Client # 10's behavioral logs and on a restraint event report should a restrictive intervention been implemented. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist	
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 record reviews 4 of 12 sampled residents (Resident #1, 2, 7 and 8) revealed annual physical evaluations had not been done within the last year by a physician. Failure to have an annual physical evaluation placed residents at risk of unidentified medical issues which could lead to deterioration in their overall health. Findings Include: All record reviews occurred between 4/13/13 and	W 322	W278 - All psychology staff members will review their client's PBSPs, PBSP Staff Instructions and Behavior Implementation Plans to ensure that all have specific positive behavior support strategies that range from the least intrusive to the most restrictive techniques and strategies to be used when	

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W 322	Continued From page 16 4/17/13	W 322	challenging behaviors are manifested. The psychologist will then train the ACM and AC Charges in the implementation of these individuals' positive behavioral support plans, as well as how to document staff members interventions from the least to most restrictive interventions in the individuals behavior log and on a restraint event report should a restraint be applied.		
W 336	Resident #1 Annual Medical Review dated 8/10/11 Resident #2 Annual Medical Review dated 4/29/11 Resident #7 Fircrest School History and Physical dated 11/12/2011 Resident #8 Fircrest School Admission History and Physical dated 10/05/2011 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record reviews facility failed to complete Quarterly Nursing Assessments for 2 of 12 sampled residents (Resident #8 and #9). Failure to complete Quarterly Nursing Assessments placed residents at risk for unmet nursing care needs. Findings include: All record reviews occurred between 4/13/13 and 4/17/13. Record review revealed Resident #8 had Quarterly Nursing Assessments completed on 2/21/12, 05/30/12 and 10/11/12. A Quarterly Nursing Assessment was not completed in the 3rd quarter during 2012.	W 336	COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Brad Chang, Chief Psychologist W322 - Annual medical evaluations for the Clients #1, #2, #7, and # 8 have been completed. Additionally, a directive has been issued to all medical providers to complete all annual medical evaluations on all PAT A clients by 6/14/13. The Medical Director/Superintendent is checking status every week to ensure compliance with the directive. COMPLETION DATE: 6/14/13 PERSON(S) RESPONSIBLE: Asha Singh, Medical Superintendent W322 - On first day of every month, each medical provider will be provided with a list of medical evaluation due that month on their case load with the expectation that all medical evaluations will be completed by the end of month. If due to some reason the medical providers		

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W 336	Continued From page 17 Record review revealed Resident #9 had Quarterly Nursing Assessments completed on 2/28/12, 5/30/12 and 1/17/13. A Quarterly Nursing Assessment was not completed in the 3rd and 4th quarter during 2012.	W 336	are unable to complete the medical evaluations assigned to them by the end of the month, they will notify their supervisor (Medical Director/Superintendent) by 20 th of that month. Medical Director/Superintendent will provide necessary assistance to ensure timely completion.		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews facility failed to ensure safe hygiene practices were being followed in 5 of 18 Units (Unit 301, 311, 312, 313 and 314). This failure placed residents at risk of being exposed to a communicable disease. Findings Include: All observations and interviews occurred between 4/13/13 and 4/17/13. Observation during the lunch meal in Unit 301 revealed staff did not wash their hands between assisting a resident in taking dirty dishes to the kitchen and then serving up another resident their meal. A staff was also observed assisting a resident with dishing up their meal by performing a hand over hand technique. The staff then performed the same procedure with another resident without washing her hands between assisting each resident.	W 455	COMPLETION DATE: 6/3/13 PERSON(S) RESPONSIBLE: Asha Singh, Medical Superintendent W336 - Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need Quarterly nursing assignments have been reviewed with all PAT A Health Care Coordinators (RN2) staff. Schedules for quarterly health assessments have been made with the expectation that the quarterly assessments will be completed in a timely manner with no exception. Each RN will submit a schedule of completion to the RN 4 by the 20 th of each month. RN3/RN4 to conduct chart reviews for compliance. The facility has completed a 100% chart review in this area and identified where there are deficiencies and corrective steps and re-training are in progress and on-going to ensure compliance.		

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W 455	Continued From page 18 Observation during the dinner meal in Unit 311, 312, 313 and 314 revealed staff failed to wear gloves and/or wash hands after touching food items and/or serving residents by performing hand over hand technique. Interview of staff on Unit 301 verified that they did not wash their hands and were unaware that hands needed to be washed when touching the resident. Another staff member stated that they were not touching the food therefore they did not need to wash their hands. Interview of staff on unit 311, 312, 313 and 314 revealed confusion about the need wear gloves and wash hands. Observations and interviews on Unit 311 revealed the facility failed to label two personal electric razors with names for Residents #5 and #24. Observations and interviews on Unit 312 revealed the facility failed to label personal electric razors with names for 4 of 6 residents (Resident #15, 16, 17 and 18). Interview of staff on both Unit 311 and 312 reported they would be unable to determine which resident owned each razor, making it difficult to provide each resident with the correct razor.	W 455	COMPLETION DATE: 6/14/13 PERSON RESPONSIBLE: Frankie Jackson, RN 4 W455 – (Infection Control) Staff will be retrained on hand washing procedures between working with individual clients and the use of gloves during meal preparation if staff are touching food without a barrier. Hand sanitizer dispensers have been installed in all PAT A dining rooms and easy-to-use food handlers' gloves will be provided by commissary. AC staff will sign training forms on this issue. COMPLETION DATE: 5/31/2013 PERSON(S) RESPONSIBLE: PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent	
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 facility failed to serve food/beverage within 15 minutes of removal from a temperature control device or failed to maintain the appropriate food	W 473	W455 – (Infection Control) ACM's have given documented expectations to AC staff that: All AC staff will look for name on razors when they do client grooming and report to the Shift Charge if label is missing. Additionally, the AM Shift charge will check all razors once a week. If labels are missing, they will make a new one or ask ACM to make a new one. AC staff have signed training forms on this issue. COMPLETION DATE: 5/31/13 PERSON(S) RESPONSIBLE: All PAT A – AC Managers Brad Benoit, Assistant Superintendent	

Brad Benoit 5/25/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE 15230 15TH NORTHEAST D SEATTLE, WA 98155	
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W 473	<p>Continued From page 19</p> <p>temperature for 7 of 10 Units (Unit 302, 307, 311, 312, 313, 316, and 318) and 1 Adult Training Program (ATP) facility (Room 88E7-Unit 319/320 Residents). Failure to serve food/beverage promptly resulted in residents being served food/beverage that had not been held at an appropriate temperature creating a potential for foodborne illness.</p> <p>Findings include:</p> <p>All observations, interviews and record reviews occurred between 4/13/13 and 4/17/13.</p> <p>All food temperatures were taken as food was being served to residents.</p> <p>Observation on Unit 302 revealed luncheon food items were being served to residents upon the arrival of the State Surveyors. The temperature of the food was taken and revealed the following: pureed noodles 126°, pureed chicken 120° and vegetables 110°.</p> <p>Observation on Unit 307 revealed dinner food items were being served to residents upon the arrival of the State Surveyors. The temperature of food was taken and revealed the following: fish filet 135°, hamburger patty 130°, peas 84° and squash 95°.</p> <p>Observation on Unit 311 revealed dinner items had been left on counter before serving for over 30 minutes. Food was served to residents without checking temperature and without reheating. The temperature of the food was taken and</p>	W 473	<p>W473 – (Meal Services) New Aladdin food trays have been ordered to replace older ones that no longer sealed properly. COMPLETION DATE: 5/31/2013 PERSON(S) RESPONSIBLE: Elisabeth Thompson, Food Services Mngr Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p> <p>W473 - Food thermometers have been supplied to each unit for measuring temperatures to ensure compliance with food temperature requirements per WAC.</p> <p>AC staff have been directed to remove bulk foods immediately upon arrival from the dietary and place them in the oven, pre-heated to 225 degrees, until</p>	

Brad Benoit 5/29/13

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W 473	<p>Continued From page 20 revealed the following: lasagna 121°, chicken 121°.</p> <p>Observation on Unit 312 revealed lunch food items had arrived from main facility kitchen at 4:20pm and were brought into the unit. The foil had been removed from serving containers at 4:45 pm but not served to residents until 5:00 pm. The food had not been reheated before serving residents. The temperature of food was taken and revealed the following: lasagna 122°, mixed vegetables 115°, macaroni and cheese 114°, milk 68°.</p> <p>Observation on Unit 313 revealed lunch food items had arrived from main facility kitchen at 11:15 am and brought into the unit at noon. Foil had been removed from serving containers at 12:05 pm but not served to residents until 12:40 pm. Food had not been reheated before serving residents. Temperatures were taken and revealed the following: pasta 118°, chicken 121°.</p> <p>Observation on Unit 313 revealed dinner items had been sitting for over 40 minutes before being served to residents. Food had not been reheated before serving residents. Temperatures were taken and revealed the following: fish Filet 105°, vegetables 117°.</p> <p>Observation on Unit 316 revealed breakfast sausage links were served at 115°.</p> <p>Observation on Unit 318 revealed noodles served at lunch were 118°.</p> <p>Observation at ATP Room 88E7 (319/320 residents) revealed spaghetti served at lunch was 115°.</p>	W 473	<p>ready for service. Cold items are to be placed in the refrigerator immediately. Buffet warming trays that hold food temperatures between 158 and 185 degrees for up to six hours were ordered for each living unit (4 per duplex) for service of hot foods in the dining room when meal time has been announced.</p> <p>For clients that receive individual trays a microwave has been placed in each dining area to warm their food before serving the individual.</p> <p>AC staff have signed training forms on all these issues. COMPLETION DATE: 5/31/2013 PERSON(S) RESPONSIBLE: PAT A - AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p>		

Brad Benoit 5/29/13

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W 473	Continued From page 21 Staff interviews revealed staff were unaware of temperature guidelines and reheating expectations when serving food. Staff in seven of the ten observed units were unable to find food thermometers in their kitchens.	W 473			
W 478	USDA guidelines recommend food must be reheated to 165 degrees Fahrenheit or above and held above 140 degrees Fahrenheit until served, in order to destroy the bacteria that can cause foodborne illness. Cold food items should be held and served at 45 degrees Fahrenheit or cooler. 483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to provide a variety of foods at each meal for 2 of 18 Units (Unit 302 & 314). Failure to provide alternatives did not give residents a choice of foods. Findings include: Observation of lunch meal on 4/14/2013 revealed residents on Unit 302 (Resident #1, 22, 61, 67, 68, and 57,) were not given the opportunity to choose what they would like to eat that would follow their diet restrictions. Residents were served the meal that was sent from the kitchen. Observation of the lunch meal on 4/14/2013 revealed that no alternative food choices had been offered to residents on Unit 314 (Resident #8, 28, 29 and 30). Alternative food choices had not been prepared by staff. Staff interviews revealed staff found it difficult to prepare alternatives due to only having two staff on shift.	W 478	W478 - (Menus) Staff on houses 301-302 and 313-314 were re-trained on the policy of preparing at minimum one alternate entree, beverage and dessert choice for each meal and to begin meal prep a minimum of 30 minutes before the arrival of trays and bulk food from dietary, to ensure that sufficient time is available for arranging the choices and pre-heating warming apparatus. DATE COMPLETED: 5/31/2013 PERSON(S) RESPONSIBLE:		

Brid Benoit

5/29/13

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W 478	Continued From page 22 Staff also revealed the unit was short food selections based on a lack of ordering through the commissary.	W 478	<p>AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p> <p>W478 - (Menus) All PAT A staff were re-trained on the policy of preparing at minimum one alternate entree, beverage and dessert choice for each meal and to begin meal prep a minimum of 30 minutes before the arrival of trays and bulk food from dietary, to ensure that sufficient time is available for arranging the choices and pre-heating warming apparatus. DATE COMPLETED: 5/31/2013 PERSON(S) RESPONSIBLE: AC Managers Muhammad Thompson, DDA1 Brad Benoit, Assistant Superintendent</p> <p>W478 - A meal-time observation check list has been developed and the DDA1, HPAs, psychologists, AC Managers and shift charges have been directed to complete at least one per week at various meals for the houses to which they are assigned. DATE COMPLETED: 5/31/2013 PERSON(S) RESPONSIBLE: AC Managers HPAs Psychologists Muhammad Thompson, DDA1 Debbie Kruse, DDA 1 Brad Benoit, Assistant Superintendent</p>		

Brad Benoit 5/29/13