

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

MAY 2 2014

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

DSHS/ADSA

OFFICE OF RATES MGMT  
CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE BUILDING IDENTIFICATION NUMBER: A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an Annual Recertification Survey conducted at Fircrest School PAT A from 03/10/14 through 03/14/14.</p> <p>A sample of 13 residents was selected from a census of 128. The expanded sample included 21 current residents.</p> <p>The survey was conducted by Penelope Rarick, B.A. Janette Buchanan, R.N., B.S. Claudia Baetge, M.A. Christina Borchardt, R.N., B.S.</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 style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">MAY 20 2014</p> <p style="text-align: center;">DSHS-ADSA Residential Care Services ICF/MR Program</p>	
W 104	<p><b>483.410(a)(1) GOVERNING BODY</b></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, interviews and record reviews, the facility failed to have a policy that provided operational direction related to the alteration of medications. This failure placed 5 of 21 expanded sample residents at risk of harm in</p>	W 104		<p>Resident # 15, 16, 17, 18, and 34's medication orders have been assessed by the medical providers and the clarified order given to the nurse. The Nursing supervisor (RN4) will review medication administration of all clients in PAT A and make sure clients receive the medication according to the order of the medical provider. Nursing Procedure I-F.6a will be</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Asha Singh</i>	TITLE <b>SUPERINTENDENT</b>	(X6) DATE <b>5/16/14</b>
--	--------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 104	<p>Continued From page 1</p> <p>receiving medications which could result in potential adverse drug reactions.</p> <p>Findings include:</p> <p>All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.</p> <p>Review of facility policy titled Preparation and Administration of Oral and/or Enteral Medications; Nursing Procedure I-F.6a revealed the following:</p> <ul style="list-style-type: none"> <li>N - Do not crush enteric-coated or time-release tablets or capsules. Contact the Pharmacist or Physician if such medications are ordered; to facilitate change to more appropriate medication/dosage.</li> </ul> <p>Nursing Procedure I-F.6a specified what medication should not be crushed. However, the Nursing Procedure was limited in that it did not provide operational directions on the Physician's Orders to reflect which medications were approved to be crushed.</p> <p>Observation of medication administration revealed nurses administering medication in accordance with Physician orders as follows:</p> <ul style="list-style-type: none"> <li>Resident #15 received Calcium 600/400 Vit. D crushed in applesauce at 3:30 pm 03/10/14.</li> <li>Resident #16 received Calcium 600/400 Vit. D crushed in pudding at 3:30 pm 03/10/14.</li> <li>Resident #17 received [REDACTED] 500 mg crushed in pudding at 3:30 pm 03/10/14.</li> <li>Resident #18 received [REDACTED] 50mg and [REDACTED] 25 mg crushed in juice with [REDACTED] 10 ml at 7:30 am 03/11/14.</li> <li>Resident #34 received [REDACTED] 05mg. tablet, Multivitamin-Mineral tablet and [REDACTED] 8.6 mg tablets on 03-10-14 at 8:00 am crushed in pudding.</li> </ul> <p>Review of Physician orders for Resident #15, 16, 17, 18 and 34 revealed no orders to crush</p>	W 104	<p>modified to indicate that medication should not be crushed unless it is specified by the provider. All PAT A nurses will be in-serviced that nurses will not crush medication without the provider order. All information that indicates clients preference to crush medications will be removed from the Medication Administration Record (MAR). Crushing medication for clinical purposes will have a physician order and will be indicated on the MAR.</p> <p>These action plans will be monitored quarterly through the medication observation sheet by lead LPN's (LPN4) and will be monitored and filed by RN4</p> <p>Completion Date: 5/14/14 Person Responsible: RN 4</p>		

*Angela*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 104	Continued From page 2 medications that were administered during observation. Review of medication bubble packs (bingo cards) or over the counter bottles of medications did not have directions from the Pharmacy or Physician that instructed Nursing staff whether a medication could or could not be crushed. Review of the residents ' Medication Administration Record (MAR) revealed a document titled Medication Book Information, which included " Medication Administration Preference. " Nursing staff dispensing medications to the residents followed the " Medication Administration Preference " section on the Medication Book Information sheet which stated for example: " Takes meds crushed with pudding. " Interview with Staff Y on 03/31/14 revealed all medication orders are to be given as ordered unless otherwise specified. Staff Y stated she would be concerned medications were being crushed which should not be and could alter the therapeutic value. She stated the original medication orders came from the Physician. When orders get to the Pharmacy, the Pharmacist alerts staff to whether there were any specialized instructions such as, whether a medication could or could not be crushed, whether a medication needs to be given prior to a meal or not, whether a medication should be given with other medications, or whether a medication should be given in the morning or evening. Interview with Staff C on 03/13/14 revealed " Medication Administration Preference " may have come from preference input from the resident/family or the dietary department. Staff C acknowledged that it was unclear as to where the document originated.	W 104			

*Angela*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 109	<p><b>483.410(b) COMPLIANCE W FEDERAL, STATE &amp; LOCAL LAWS</b></p> <p>The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to comply with State Regulation (WAC 246-215-04710) ensuring all equipment, food contact surfaces and utensils were sanitized. This failure placed residents at risk for illness due to exposure by cross contamination.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified.</p> <p>Interview with Staff S indicated the main kitchen dishwasher temperature is checked daily to ensure the correct temperature is reached for the sanitization process. Kitchen staff place a Thermolabel (temperature sensitive tape) on an item that goes through the dishwasher-ensuring hot water sanitation. At the end of the dishwashing cycle, the Thermolabel is placed on the Dishwashing Machine Temperature Chart. Record review of the Dishwashing Machine Temperature Chart for March 2014 revealed after the dishwasher temperatures were checked, Thermolabels were placed on the chart in an</p>	W 109	<p>The chart for the retention of the Thermolabel was revised so that there would be no overlapping labels. All staff were again trained on the requirements for the wash, rinse and sanitizing process when the dishwasher is not available for use. Signs with the correct process were posted at the sinks for easy reference. The dishwasher / sanitizer was fixed during the time of the survey. This issue was added to the supervisor's checklist as a monitoring tool. They are to look at the chart with the Thermolabels to assure that the correct process is being followed. If the dishes are being washed by hand, the supervisor is to monitor the process to assure that the correct mix of sanitizing solution is used for washing.</p> <p>Completion Date 3/14/14 Person Responsible: Food Services Manager</p>		

*Asugh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 109	Continued From page 4 overlapping manner making it difficult to determine which days the dishwasher temperatures were checked. There were no readings on March 1st and 2nd and only two days in which readings displayed the desired temperature of 160°. Staff S acknowledged she had not been notified of problems with the dishwasher and she was unable to determine how long there had been problems with the temperature sanitation cycle. Interview with Staff S revealed when the main kitchen dishwasher was not available for use, staff would use the three compartment sink to wash, rinse and sanitize tableware, utensils and equipment. Observation of wash, rinse and sanitize process revealed staff did not understand how to sanitize tableware, utensils and equipment correctly or how long to sanitize items. When interviewed how long items were sanitized: Staff S responded 1 minute, Staff T indicated 20 seconds and Staff U was not sure.	W 109			
W 116	483.410(c)(6) CLIENT RECORDS  The facility must provide each identified residential living unit with appropriate aspects of each client's record.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff had access to the most current and relevant information for 6 of 13 sampled residents (Resident #4, 8, 10, 11, 12, & 13) available in resident program books, dining books and/or main chart. This failure placed residents at risk of receiving inappropriate care due to staff not	W 116	A work group developed a standardized process for content within client program books that will be used in the Program Area Team (PAT). Program books will be assigned per client staffing post. Each interdisciplinary team will review the program book annually and when programs change to ensure that each book contains the most recent version of the Implementation Plans for each client.		

*Asangh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 116	<p>Continued From page 5 knowing residents ' current functioning level, medical issues, dietary issues and restrictive practices.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified.</p> <p>Program books with missing Positive Behavioral Support Plans (PBSP): Resident #8, Resident #10, Resident #12 and Resident #13. Program books with outdated PBSP ' s: Resident #11. Program books with outdated PBSP Directions for Staff: Resident #4. Observation of units revealed each unit had a different approach for what resident information was available for staff and how information is provided for staff. Some units provided one program book per resident which may include training/behavioral/medical information. Other units had combined resident program books and/or several program books per resident. Interview with Staff I and J revealed based on information being out of date in program books, unit staff refer to the resident ' s main red book when training new staff. Interview with Staff L, M and N revealed Program Books are used by staff to help understand the needs of residents. Interview with Staff Q revealed floating staff, unfamiliar with the unit, have expressed difficulty finding relevant resident information due to inconsistencies regarding the types and quantities of resident program books on each unit. Interview with Staff B acknowledged program books must include the most updated and</p>	W 116	<p>Dining books will be reviewed by the Attendant Counselor Managers to ensure that the most recent version of the Nutritional Management Plan and Dining Guidelines are in place. Dietary staff will review dining books monthly to ensure that the most recent Diet Orders are within the Dining Book and the chart. The QI Department will monitor one program and one dining book per house (picked randomly) one time monthly to assure that the information contained in the books is current. The results of these random checks will be given to the PAT A Director and DDA1 for followup as needed.</p> <p>Target Completion Date: 5/14/14 Person Responsible: DDA 1; PAT A Director</p>		

*Angela*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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)
W 116	Continued From page 6 relevant resident information however Staff B agreed the facility does not have uniformed approach for how or what type of resident information is offered in program books. Observation of resident meal books/main chart revealed the following: Resident #5: Review of dining book and resident main chart revealed Dining Guidelines Latest Updates-Diet Orders: 10/10/11 and Nutritional Management Plan (NMP): 09/14/2012. Staff W provided an updated Dining Guidelines for Resident #5 which revealed updated information to include Diet Orders: 1/23/14 and NMP: 09/13/13. The updated Dining Guidelines document was not found in the resident dining book or main chart.	W 116	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM  For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff followed directions with regards to the [REDACTED] magnet for 1 of 13 sampled residents (Resident #6). This failure placed resident at risk of medical complications from an unmanaged [REDACTED]  Findings include:  All observations, record reviews and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.	W 192	Written expectations have been given to the Attendant Counselors (AC) staff on 311/312 regarding the use of the [REDACTED] for resident #6. A form was developed for the staff on any unit with a client who has a [REDACTED] to document the exchange of the [REDACTED] between the shifts to ensure its location. All AC staff who support clients who have [REDACTED] magnets will be re-trained on the [REDACTED] guidelines that the expectation that the [REDACTED] magnet is on their person at all times.

*Boyle*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 192	Continued From page 7 Review of Resident #6 's Annual Medical Review (06/12/13) revealed Resident #6 was diagnosed with a [REDACTED] disorder and had a [REDACTED]. [REDACTED] is used to prevent [REDACTED] by sending regular, mild pulses of electrical energy to the brain via the [REDACTED]. If the regular interval electrical pulses do not prevent [REDACTED] a magnetic wand can be used to deliver an extra pulse of stimulation. This extra electrical stimulation can stop the [REDACTED] or reduce the [REDACTED] severity. Review of nursing directions to staff (11/07/13) revealed staff should keep the [REDACTED] on their person at all times and away from credit cards and watches. If staff notice any symptoms of [REDACTED] activity they are to immediately use the [REDACTED] by passing [REDACTED] over the area from his [REDACTED] ampit to his [REDACTED] nipple 1-2 times, if [REDACTED] does not stop, repeat after 5 seconds and keep repeating. Observation of Unit 312 at 4:00pm on 03/12/14 revealed [REDACTED] wrapped around staff walkie talkie radio and left on chair outside of Resident #6 's bedroom. Staff X was providing 1:1 supervision with Resident #6 in living room area for approximately 15 minutes. Interview with Staff X revealed she failed to have [REDACTED] in her possession while supervising Resident #6 in the living room. Staff X stated the unit had two extra [REDACTED] both located behind locked cabinets in the living area. However Staff X acknowledged due to her failing to have [REDACTED] in her possession she would have been unable to provide immediate medical intervention if a [REDACTED] were to occur.	W 192	A question was added to the PAT A Observation form checking whether a staff who is assigned to a client who uses a [REDACTED] has it on their person. Appropriate action will be taken if the staff does not have the [REDACTED] on their person. The PAT Observation forms are given to the PAT A Director for oversight.  Target Completion Date: 5/14/14 Person Responsible: Acting PAT A Director; RN4	
W 262	483.440(f)(3)(i) PROGRAM MONITORING &	W 262		

*Amogh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 262	<p>Continued From page 8 CHANGE</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 observations, interviews, and record reviews, the facility failed to ensure Human Rights Committee (HRC) had reviewed and/or approved restrictive procedures for 2 of 13 sampled residents (Resident #10 &amp; 13), 2 of 21 expanded sampled residents (Resident #14 and 34) and 5 of 18 Units (Unit 308, 315/316 and 319/ 320). This failure placed residents at risk of harm due to facility using restrictive procedures that were not approved by the HRC.</p> <p>Findings include:</p> <p>All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.</p> <p>Resident #10: Record review revealed Resident #10 ' s HRC Restrictive Procedures Review Tracking Form for residents Positive Behavior Support Plan (PBSP) had not been reviewed or updated by HRC since 08/09/12.</p> <p>Review #13: Observation revealed Resident #13 had a [REDACTED] placed on a wheelchair between resident ' s legs in order to prevent resident from sliding forward. This restrictive device must be removed by staff in</p>	W 262	<p>Resident #10's Positive Behavior Support Plan (PBSP) has been reviewed by the Human Rights Committee (4/10/14).</p> <p>A consent for use of the [REDACTED] on the wheel chair of resident #13 was obtained by telephone on 3/15/14. The restrictive process will be reviewed by the Human Rights Committee and a written consent approval will be sought by the guardian in May.</p> <p>Resident #14's clothing is no longer locked up in the supply room and she has access to it.</p> <p>Resident #34 was incorrectly identified and should now be resident #35. The cabinet has been unlocked and a work order placed to have the hasp taken off the cabinet so it can't be locked in the future.</p> <p>The cabinet containing hygiene/ grooming kits and razors on house 308 is no longer locked.</p> <p>The cabinet on 315/316 containing Depends undergarments, wipes and toilet paper is no longer locked.</p> <p>Consents for locking the exterior gates around 319/320 have been sent out to guardians. As the consents come back signed, the restrictive procedure is</p>		

*Anger*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 262	Continued From page 9 order for resident to enter and exit the wheelchair. Review of Resident #13 's record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Resident #14: Observation revealed Resident #14 had two boxes of clothes stored in the unit 's locked supply room. Resident #14 was aware of the additional clothes in the locked room but must ask for staff assistance to access the locked room. Review of Resident #14 's record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Resident #34: Observation revealed a locked cabinet in the dining room which contained snack items for Resident #34. Review of Resident #34 's record revealed no documentation to indicate HRC had reviewed and/or approved the restrictive procedure before it was implemented. Unit 308: Observation revealed a locked cabinet which secured hygiene/grooming kits and razors for residents. Interview of Staff K revealed items had been locked due to a safety concern regarding a unit resident who ingests dangerous substances to include liquid items such as shampoos and/or metal and plastic items. Staff K acknowledged HRC had not reviewed and/or approved the restrictive procedure before it was implemented. Unit 315/316: Observation of Unit 315/316 revealed locked cabinets in the bathrooms which contained Depends undergarments, wipes and toilet paper.	W 262	being reviewed by the Human Rights Committee. A training on restrictive processes or actions will be held for all interdisciplinary team members in PAT A so that future restrictions on PAT A clients will receive approval from guardians and the Human Rights Committee prior to initiation of the restrictive process or action. Target Completion Date: 5/14/14  Person Responsible: PAT A Director, DDA 1 and Lead Psychologist		

*Angela*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 262	Continued From page 10 Review of Unit 315/316 resident records revealed HRC had not reviewed and/or approved the restrictive procedure before they were implemented. Unit 319/320: Observation of Unit 319/320 revealed there were four exterior gates (3 in the back of the unit and 1 off the patio in the front) which restricted 16 residents from entering and exiting the unit without the assistance of the staff. Interview with Staff D acknowledged the gates were locked due to the concerns regarding potential elopement of two residents. Review of records that reside on Unit 319/320 revealed that two residents out 16 residents on the unit were at risk of elopement HRC had not reviewed and/or approved the restrictive procedure before it was implemented.	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 observations, record reviews and interviews, the facility failed to ensure residents' guardians reviewed and/or approved restrictive procedures for 1 of 13 sampled residents (Resident #13), 2 of 21 expanded sample residents (Resident #14 and 34) and 5 of 18 Units (Unit 308, 315/316 and 319/320). This failure denied the residents/guardians the opportunity to make informed decisions about facility restrictive practices and denied residents'	W 263	The Human Rights Committee was unable to review the restrictions identified as they were not presented with the process for review. A training on restrictive processes or actions will be held for all interdisciplinary team members in PAT A so that future restrictions on PAT A clients will receive approval from guardians and the Human Rights Committee prior to initiation of the restrictive process or action.  Resident #10's Positive Behavior Support Plan (PBSP) has been reviewed by the Human Rights committee (4/10/14).		

*rough*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 263	<p>Continued From page 11 their right of free access to their property.</p> <p>Findings include:</p> <p>All observations, record reviews and interviews were completed between 03/10/2014 and 03/14/2014, unless otherwise specified.</p> <p>Resident #13: Observation revealed Resident #13 had a [redacted] placed on a wheelchair between resident 's legs in order to prevent resident from sliding forward. This restrictive device must be removed by staff in order for resident to enter or exit the wheelchair. Review of Resident #13 ' s record revealed no documentation to indicate guardians had reviewed and/or approved the restrictive procedure before it was implemented.</p> <p>Resident #14: Observation revealed Resident #14 had two boxes of clothes stored in the unit ' s locked supply room. Resident #14 was aware of the additional clothes in the locked room but must ask for staff assistance to access the locked room. Review of Resident #14 ' s record revealed there had been no guardian review and/or approval of the restrictive procedure before it was implemented.</p> <p>Resident #34: Observation revealed a locked cabinet in the dining room which contained snack items for Resident #34. Interview with Staff P acknowledged cabinet should not have been locked and there had been no guardian review and/or approval of the restrictive procedure before it was implemented.</p> <p>Unit 308: Observation of Unit 308 revealed a locked</p>	W 263	<p>A consent for use of the [redacted] on the wheel chair of resident #13 was obtained by telephone on 3/15/14. The restrictive process will be reviewed by the Human Rights Committee and a written consent approval will be sought by the guardian in May.</p> <p>Resident #14's clothing is no longer locked up in the supply room and she has access to it.</p> <p>Resident #34 was incorrectly identified and should now be resident #35. The cabinet has been unlocked and a work order placed to have the hasp taken off the cabinet so it can't be locked in the future.</p> <p>The cabinet containing hygiene/ grooming kits and razors on house 308 is no longer locked.</p> <p>The cabinet on 315/316 containing Depends undergarments, wipes and toilet paper is no longer locked.</p> <p>Consents for locking the exterior gates around 319/320 have been sent out to guardians. As the consents come back signed, the restrictive procedure is being reviewed by the Human Rights Committee.</p> <p>Person Responsible: PAT A Director, DDA 1 and Lead Psychologist Target Completion Date: 5/14/14</p>	

*Amogh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 263	Continued From page 12 cabinet which secured hygiene /grooming kits and razors for residents. Interview of Staff K revealed items had been locked due to a safety concern regarding a unit resident who ingests dangerous substances which include liquid items such as shampoos and/or metal and plastic items. Staff K acknowledged there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Unit 315/316: Observation of Unit 315/316 revealed locked cabinets in the bathroom which contained Depend under garments, wipes and toilet paper. Interview with Staff N revealed bathroom cabinets were routinely locked up. Record review revealed there had been no guardian review and/or approval of the restrictive procedure before it was implemented. Unit 319/320: Observation of Unit 319/320 revealed there were four exterior gates (3 in the back of the unit and 1 off the patio in the front) which restricted 16 residents from entering and exiting the unit without the assistance of the staff. Interview with Staff D acknowledged the gates were locked due to the concerns regarding potential elopement of two residents. Review of records that reside on Unit 319/320 revealed that two residents out 16 residents on the unit were at risk of elopement which guardians had not reviewed and/or approved the restrictive procedure before it was implemented.	W 263			
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.	W 323	Residents #6, #9, #10, #12 and #13 have had vision exams scheduled.		

*Boyer*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 323	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 5 of 13 sampled residents (Resident #6, #9, #10, #12, &amp; #13) received annual and/or as recommended vision exams. Failure to provide a timely vision exam placed residents at risk of unidentified changes in vision and other medical issues which could lead to deterioration in their overall health.</p> <p>Findings include:</p> <p>All record reviews and interviews were completed between 03/10/14 and 03/14/14, unless otherwise specified.</p> <p>Resident #6: Review of medical chart revealed resident had not had a vision exam since being admitted to facility on [REDACTED] 2011.</p> <p>Resident #9: Review of Ophthalmology Consultation dated 09/07/12 revealed resident had developing [REDACTED] which were gradually worsening. Assessment recommendations included holding off on surgery and to recheck in another year.</p> <p>Interview with Staff O acknowledged that Resident #9 had not been rechecked since exam dated 09/07/12.</p> <p>Resident #10: Record review revealed that the last vision exam was 07/07/08 with a recommendation for resident to have his eye sight followed on a routine basis. There was no documentation provided to indicate a follow up exam had occurred.</p> <p>Resident #12: Review of medical chart revealed resident had not had a vision exam since being admitted to facility on [REDACTED] 11.</p>	W 323	<p>A review of all other PAT A clients will occur to assure that all clients have had a vision exam based upon their particular clinical needs, or an initial exam as a baseline.</p> <p>Admission History and Physical and Annual Medical Evaluations include evaluation of the client's eyes, as well as review of health history, including ophthalmologic. The health care provider will request ophthalmologic consultation for any concerns.</p> <p>At each Individual Habilitation Plan (IHP) meeting, the Health Care Coordinator (RN) will review the chart to ensure consultations are completed and treatment plans implemented.</p> <p>Target Completion Date: 5/14/14 Person Responsible: RN 3</p>	

*Handwritten:*  
Arough  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 323	Continued From page 14 Resident #13: Record review revealed last vision exam had been 01/20/00 with recommendations to have a routine follow up vision exams. There was no documentation provided to indicate a follow up exam had occurred.	W 323			
W 362	<b>483.460(j)(1) DRUG REGIMEN REVIEW</b>  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 reviews and interviews, the facility failed to ensure a pharmacist provided thorough reviews of drug regimens for 13 of 13 sampled residents (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13) during the quarterly review process. This failure placed residents at risk of inappropriate medication management and risk for potential medication errors.  Findings include:  All record reviews and interviews were completed on 03/10/14 through 03/26/14 unless otherwise specified.  Review of Pharmacy Notes revealed each pharmacist had a different approach regarding how drug regimens were reviewed for each resident. Pharmacy Notes failed to include a review of all drugs in residents' drug regimen, failed to consistently indicate which drugs were reviewed, failed to consistently describe the	W 362	A separate tab labeled "Pharmacy" will be added to each client's chart. This section will contain the following standardized information for each 90 day pharmacy review: <ul style="list-style-type: none"><li>• Client name, home, ID#, date of birth</li><li>• Immunizations</li><li>• Acute Medical Problems in the past 90 days</li><li>• Current medication list with dosage and frequency information</li><li>• Diagnoses with recent laboratory results, any appointments, consultations, medication usage and response during this period</li><li>• Laboratory results and schedule for routine screening</li><li>• Recommendations by Clinical Pharmacist with outcomes</li><li>• Clinical Pharmacist's signature and date</li></ul>		

*Handwritten:*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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)	(X6) COMPLETION DATE
W 362	<p>Continued From page 15 residents ' response to the drug regimen and failed to be signed by the pharmacist.</p> <p>Review of Pharmacy Notes revealed no evidence to support a complete review of drug regimen or response to the drug regimen for the following residents:</p> <p>Resident #1 Review of Resident #1 Medication Administration Record (MAR) dated 2/21/14 revealed a medication regimen to include: [REDACTED] and [REDACTED] Pharmacy Notes dated 3/5/14 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug.</p> <p>Resident #2 Review of Resident #2 MAR dated 12/23/13 revealed a drug regimen to include: Acetaminophen, Baby oil, Coal Tar, Ducosate Sodium, [REDACTED] Pharmacy Notes dated 1/7/14 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug.</p> <p>Resident #3 Review of Resident #3 ' s MAR dated 12/23/13 revealed a drug regimen to include [REDACTED] [REDACTED] Pharmacy Notes dated 12/23/13 did not include a list of reviewed drugs or information regarding the resident ' s response to each drug.</p>	W 362	<p>The Pharmacy Supervisor will conduct random chart reviews of each Clinical Pharmacist's assigned areas to ensure that the consistent and standardized input of the clinical pharmacist is clearly reflected in the record of each client.</p> <p>COMPLETION DATE: 5/09/14 PERSON(S) RESPONSIBLE: Lead Pharmacist Pharmacy Supervisor</p>	

*Handwritten:*  
Hough  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 362	Continued From page 16  Resident #4 Review of Resident #4 Medication Profile revealed a drug regimen to include: [REDACTED] [REDACTED] Pharmacy Notes dated 1/7/14 did not include a list of reviewed drugs or information regarding the residents' response to the drug.  Resident #5 Review of Resident #5 Medication Profile revealed a drug regimen to include: Aspirin, [REDACTED] [REDACTED] and [REDACTED] Pharmacy Notes dated 1/22/14 did not include a list of reviewed drugs or information regarding the residents' response to the drugs.  Resident #6 Review of Resident #6 Medication Profile revealed drug regimen to include: Biotin, [REDACTED] [REDACTED] Vitamin E, Vitamin B2, and [REDACTED] Pharmacy Notes dated 1/29/14 did not include a list of reviewed drugs or information regarding the residents' response to the drug.  Resident #7 Review of Resident #7 Medication Profile revealed a drug regimen to include: [REDACTED] Pharmacy	W 362		

*Angela*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 362	<p>Continued From page 17</p> <p>Note dated 02/04/2014 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #8 Review of Resident #8 Medication Profile revealed a drug regimen to include: Calcium Carb/Vitamin D, [REDACTED] Multivitamin, [REDACTED] Petrolatum/Mineral Oil Oph Oint for [REDACTED] Pharmacy Note dated 03/11/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #9 Review of Resident #9 Medication Profile Review revealed a drug regimen to include: [REDACTED] Multivitamins-Minerals [REDACTED] Powder, Calcuim Carb/Vit D and Carbamide Perox ear drops. Pharmacy Note dated 03/11/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #10 Review of Resident #10 ' s Patient Medication Profile revealed a drug regimen which included [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] 1% Powder. Pharmacy Notes dated 02/11/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #11 Review of Resident #11 ' s Patient Medication</p>	W 362		

*Asanga*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 362	<p>Continued From page 18</p> <p>Profile revealed a drug regimen which included Vitamin D and [REDACTED] Pharmacy Notes dated 02/11/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #12 Review of Resident 12 ' s Patient Medication Profile revealed a drug regimen which included [REDACTED] daily cleanser, and [REDACTED]. Pharmacy Notes dated 01/15/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Resident #13 Review of Resident #13 ' s Patient Medication Profile revealed a drug regimen which include [REDACTED] 0.05% [REDACTED] 0.05% [REDACTED] Daily Cleans (Generic), [REDACTED] (for [REDACTED] and [REDACTED] 10 mg Supp. Pharmacy Notes dated 01/15/14 did not include a list of reviewed drugs or information regarding the resident ' s response to the drug.</p> <p>Interview with Pharmacy team revealed the Pharmacy Notes are completed during the 90 Day Interdisciplinary Team (IDT) meeting. Pharmacists revealed the IDT meeting didn ' t always provide enough time to document a complete drug review. The pharmacists</p>	W 362		

*Asyle*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 362	Continued From page 19 acknowledged inconsistencies with the type of information provided in the Pharmacy Notes. The Pharmacy team acknowledged they do not provide a copy of the Pharmacy Notes for the residents ' chart as required per policy (Procedure for Medication Regimen Review #p.1.2 revised 08/2013) nor sign the Pharmacy Notes.	W 362			
W 382	<b>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</b>  The facility must keep all drugs and biologicals locked except when being prepared for administration.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to keep medication carts locked during medication administration for 2 of 18 units (Unit 309 (317) & 315). This failure placed residents at risk of harm due to accessibility of unsecured drugs.  Findings include:  All observations and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.  Observation on 03/10/14 on Unit 315 revealed Staff V had placed the medication cart in the center of living room. Staff was observed quickly returning to the unlocked medication cart after dispensing medication to a resident approximately 20 feet from the cart. Interview with Staff V acknowledged this was acceptable per policy, as long as she could see	W 382	Staff V and all other nursing staff will be in-serviced that medication carts need to be secured and in front of the nursing staff at all times. Even if the cart is within a line of sight, if the nurse steps away from the cart the cart needs to be locked at all times. If the resident cannot come up to the cart to take their medication, the nurses need to take the medication cart and the Medication Administration record with them to the client location and administer the medication. The Nursing supervisor (RN4) observed the medication administration by nurses of all clients in PAT A to assure the med cart was secured and locked according to the procedure and nursing practice. Medication cart security procedure will be added on the Nursing procedure I-F.6a		

*Boyle*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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)	(X6) COMPLETION DATE
W 382	Continued From page 20 the medication cart. Observation on 03/11/14 on Unit 309 (317) revealed the medication nurse brought the medication cart into living room area and parked medication cart on far side of living room. Staff walked over to the sink on opposite side of the room to fill her water container and left cart unlocked and within reach of a resident. Interview with Staff C revealed nursing practice dictates medication carts should be in front of the nurses at all times and if resident does not come up to the cart the nurse is to lock the cart and take the medication to the resident or bring the cart to the resident in order to administer medication.	W 382	The HCC (RN2) and the LPN 4 will observe medication administration of all clients in PAT A quarterly and sporadically and do spot checks to make sure nurses follow Nursing Procedure I-F.6a and report to RN4.  Target Completion Date: 5/14/14 Person Responsible: RN 4	
W 424	483.470(d)(1) CLIENT BATHROOMS  The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed ensure 2 of 2 bathrooms had mirrors by the sink/tooth brushing area for 1 of 13 sampled residents (Resident #5) and 6 of 21 expanded sampled residents (Resident #19, #20, #21 #22, #23 and #24). This failure prevented residents from maintaining good hygiene and violated residents' right to independence, personal choice and dignity.  Findings include:  All observations, record reviews and interviews occurred between 03/09/14 and 03/14/14 unless otherwise specified.	W 424	Non-breakable plastic mirrors were installed in the bathrooms and secured to the wall on house 308. The issue of bathrooms having all necessary components (mirrors, toilet paper, etc.) will be included in a new QI Rights/Restrictions checklist. This checklist will be completed by QI staff and the results of these observations given to the PAT A Director for appropriate followup.  Target Completion Date: 5/14/14  Person Responsible: PAT A Director QI Director	

*Spangh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 424	Continued From page 21  Observation of unit 308 revealed both resident bathrooms failed to have mirrors. Interview of staff revealed Resident #20 had ingested some glass after breaking a picture frame. In response to safety concerns for Resident #20, all glass items were immediately removed from area, including the bathroom mirrors. Interview of Staff G acknowledged there had been discussion regarding bathroom mirror replacement and the best way to offer a reflective mirror type device that would not place Resident #20 at risk if he were to break or ingest the frame or glass. Staff G revealed they had not yet determined how or when the bathroom mirrors would be replaced. Review of facility Incident Report (02/08/14) revealed bathroom mirrors were removed on 02/08/14. The facility failed to provide bathroom mirrors for five weeks.	W 424			
W 441	<b>483.470(i)(1) EVACUATION DRILLS</b>  The facility must hold evacuation drills under varied conditions.  This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure evacuation drill times and evacuation routes varied during evacuation drills for all units. This failure placed residents at risk of harm should an emergency occur that necessitates evacuation.  Findings include:	W 441	Fire evacuation drills will be conducted at varied times. Some drills will be conducted on the weekends to include clients who may be at school or week during the work week to accommodate this requirement. Evacuation routes will be varied by indicating to staff the location of the practice fire and changing the location of the practice fire each drill.		

*Handwritten:*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 441	Continued From page 22  All record reviews and interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified.  Review of facility 2013 Fire Drill Schedule revealed quarterly drill times for 2nd shift were performed within the same two hour time frame on units 301/302, 303/304, 305/306, 307/308, 311/312, 313/314, 315/316, 317/318, and 319/320. Quarterly drill times for 3rd shift were performed within the same two hour time frame on 301/302, 303/304, 305/306, 311/312, 313/314, 315/316 and 317/318. Interview of Staff K revealed daytime shift fire drills were planned around resident Active Treatment Program schedules and staff availability. Staff K acknowledged drill times were not varied to include different times of the day and for the 2nd and 3rd shift. Review of All-Hazards operations Plan Drill Forms for 2013 revealed houses 303/304, 305/306, 307/308, and 309/310 (317/318) all practiced full evacuations out the patio door and had no variation with evacuation routes. Interview of Staff K revealed each house has 7 potential exits. During fire drills Staff K provides a mock fire situation for each house and acknowledged that based on these mock situations the houses would naturally exit out the back patio. Staff K acknowledged the mock situations did not allow a practice opportunity for staff and residents to vary the evacuation routes.	W 441	The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that all requirements of the drill have been met. The Safety Officer will teach the staff initiating the drill about the various requirements of the drill if it is not initiated by the Safety Officer.  Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement		
W 445	483.470(i)(2)(i) EVACUATION DRILLS  The facility must actually evacuate clients during at least one drill each year on each shift.	W 445	A full evacuation drill will be scheduled to be conducted on the night (NOC) shift during the warmer weather of the summer months so as to not put clients		

*Apugh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 445	Continued From page 23  This STANDARD is not met as evidenced by: Based on interviews the facility failed to evacuate residents during at least one drill each year on each shift (3rd shift -overnight) during 2013. This failure placed residents at risk of harm from potential entrapment if an emergency should occur that necessitates evacuation during the 3rd shift.  Findings include:  All interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified.  Interview of Staff K revealed there had been no actual evacuation drills done during the 3rd shift (overnight) for any of the units during the past 12 months.	W 445	at risk of exposure to the cold and rain. A plan for neighboring houses and the duty office to assist the home that is conducting the drill will be implemented for supervision of the clients once they have been physically evacuated.  The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that an evacuation drill occurs on night shift during the calendar year.  Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement	
W 447	483.470(i)(2)(iii) EVACUATION DRILLS  The facility must file a report and evaluation on each evacuation drill.  This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to file an accurate report and evaluation of each evacuation fire drill. This failure placed residents at risk of harm from potential entrapment if an emergency should occur that necessitates evacuation and caused facility to be unaware of problems which might arise during a fire drill.	W 447	The Fire Drill form has been revised to allow for indicating whether there was a full evacuation, a partial evacuation or no evacuation. The person conducting the drill and completing the form will indicate reason for not evacuating. A comment section will also be added so that additional information may be added to the form. A situation will be developed for each drill and which exits are used. Exits will be varied throughout the year to meet this requirement.	

*As of  
5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 447	<p>Continued From page 24</p> <p>Findings include:</p> <p>All record reviews and interviews occurred between 03/10/14 and 03/14/14 unless otherwise specified.</p> <p>Record Review revealed each of the 18 units (9 houses) had four quarterly fire drills during 2013.</p> <p>Interview of Staff K revealed at the time of each drill a designated staff-typically the safety officer (Staff K) or designated Duty Officer (3rd shift) observes the drill, completes an All-Hazards Operations Plan Drill form and identifies any problems or corrective actions based on the outcome of the drill.</p> <p>Review of the All-Hazards Operations Plan Drill form revealed the form was incorrectly completed by staff and staff failed to include accurate information which would allow the opportunity to identify problems.</p> <p>Examples included as follows:</p> <p>Drill Evacuations: The form included a section showing " exit used " in regards to the drill evacuation exit. The section had been completed by staff however staff did not distinguish between a mock evacuation and actual evacuation, e.g., All-Hazards Operations Plan Drill form dated 9/18/13 NOC shift Unit 301/302 revealed evacuation exit used was back patio. Interview of Staff K revealed this evacuation was a mock evacuation, not an actual evacuation, even though it was documented that the back patio was used as an exit. Staff K acknowledged when</p>	W 447	<p>Actual time taken to evacuate will be provided during the full evacuation drill. No time to evacuate will be documented at other fire drills.</p> <p>Comments from staff related to the Fire Drill will be recorded on the Fire Drill form. Any issues identified will be resolved in a timely manner.</p> <p>The Quality Improvement Director will review all fire evacuation drill paperwork on a monthly basis to assure that all requirements of the drill have been met. The Safety Officer will teach the staff initiating the drill about the various requirements of the documentation of the drill if it is not initiated by the Safety Officer.</p> <p>Target Completion Date: 5/14/14 Person Responsible: Safety Officer and Director of Quality Improvement</p>		

*Abigail*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 447	<p>Continued From page 25</p> <p>reviewing the form it would be difficult for anyone but him to know if the evacuation drill was a mock versus an actual evacuation.</p> <p>Time to Evacuate: Review of documentation revealed all evacuations ranged between one and three minutes, e.g., All-Hazards Operations Plan Drill form dated 3/20/13 NOC shift Unit [REDACTED] revealed time to evacuate 16 clients with 3 staff at 04:06AM was 1 minute. However interview of Staff K revealed this drill was a mock evacuation, not an actual evacuation, so the time listed was based on how long staff believed it would take to evacuate residents rather than an accurate evacuation time.</p> <p>Incomplete information: Review of documentation revealed during the course of the year, several sections of the All-Hazards Operations Plan Drill form had been left blank. This included fire drill time, name of the person completing the form, problems encountered, and inspection of portable fire extinguishers.</p> <p>Staff K acknowledged at times he failed to review the form to ensure its completion. He also acknowledged as part of his job he should review and sign all forms which had been completed by another staff and agreed he had not consistently done this.</p> <p>Based on the inaccuracies and incompleteness of documentation on the All-Hazards Operations Plan Drill form one would be unable to accurately evaluate and determine if any problems occurred during a drill/evacuation.</p>	W 447			
W 454	483.470(l)(1) INFECTION CONTROL	W 454	The plastic scoop that was used for		

*Handwritten:*  
Hough  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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	<p>Continued From page 26</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: Based on observations and interviews, the facility failed to provide a sanitary environment that was free from items and areas contaminated with urine for 1 of 13 sampled residents (Resident #5) and 6 of 21 expanded sampled residents (Resident #19, #20, #21 #22, #23 and #24). This 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 03/09/14 and 03/14/14 unless otherwise specified.</p> <p>Observation of resident bathroom in Unit 308 revealed two plastic scoop-like items placed on bottom panel of the cabinet, underneath bathroom sink.</p> <p>Interview of staff revealed the plastic items were used as a urine shield when Resident #19 was on the toilet. Staff explained Resident #19 had a medical condition which [REDACTED]</p> <p>[REDACTED] Resident #19 will [REDACTED]</p> <p>Interview of staff revealed after use, Resident #19 would rinse the plastic shield in the bathroom sink and place the plastic shield under sink on bottom panel of the cabinet. Staff revealed there is no system in place requiring Resident #19, or staff,</p>	W 454	<p>resident #19 was eliminated as he was able to be taught to use the toilet appropriately without the scoop. A question about correct sanitization processes will be added to the new QI Rights/Restrictions checklist. This checklist will be completed by QI staff and the results of these observations given to the PAT A Director for appropriate followup.</p> <p>Target Completion Date: 5/14/14 Person Responsible: PAT A Director QI Director</p>	

*Handwritten:*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 27 to sanitize the [REDACTED] sink and countertop and bathroom cupboard after use of the [REDACTED]	W 454		
W 455	483.470(l)(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 observation and interviews, the facility failed to observe infection control practices when storing and charging electric razors for residents in 1 of 18 units (Unit 308). This failure placed residents at risk for illness from cross contamination.  Findings include:  All observations and interviews occurred between 03/09/14 and 03/14/14 unless otherwise specified.  Observation of Unit 308 on 03/09/14 revealed six resident razors co-mingling in a small plastic container in dayroom cabinet. Observation of Unit 308 on 03/11/14 revealed five residents' razors being recharged and co-mingling in a small plastic container in cabinet of television stand located in the day room.  Interview of staff revealed razors are should be stored in residents' individual hygiene containers, however when being charged they are	W 455	The Attendant Counselor Manager has given written expectations for the correct storage of client razors. The razors for clients living on 307/308 are now stored in the client's bedrooms. Proper storage of client razors will be added to the Unit Check lists to ensure that razors are not stored together. The checklists will be monitored by the Attendant Counselor Manager. In addition, a member of the QI staff will check on proper storage of razors in addition to other practices that may be interpreted as an infection control issue as part of a random check on PAT A houses. The QI checklist will be given to the PAT A Director for followup when issues have been found.  Target Completion Date: 5/14/14  Person Responsible: AC Manager for house 307/308 PAT A Director Director of Quality Improvement	

*Amogh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 455 W 460	<p>Continued From page 28 co-mingled in the plastic container.</p> <p><b>483.480(a)(1) FOOD AND NUTRITION SERVICES</b></p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow dining guidelines for 2 of 13 sampled residents (Resident #4 and 7) and 2 of 21 expanded sampled residents (Resident #25 &amp; 26). This failure caused residents to be served food that was not suitable size or texture for their eating and swallowing ability, placing residents at risk of harm of choking and/or aspiration.</p> <p>Findings include:</p> <p>All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.</p> <p>Resident #4: Review of Resident #4 's dining guidelines revealed resident has [REDACTED] with [REDACTED]. He takes food, eats and drinks large amounts rapidly especially with favored foods. He is at moderate risk for choking and aspiration. Adaptive equipment included using a [REDACTED] for [REDACTED]. Management during meals included reminding him to put his fork/spoon down between bites and wait if he started to eat too fast; use gestures, physical prompts to slow</p>	W 455 W 460	<p>Dietary Department will assure that food is cut up into small, manageable bite size pieces for those clients with a Nutritional Management Plan requiring small pieces of food. The Occupational Therapist will provide a template to the Food Service Manager and Attendant Counselor Managers showing the appropriate size the food should be cut, as well as healthy serving size. The Food Service Manager will in turn provide this information to the Dietary staff. Attendant Counselor Managers will post the template diagram in dining rooms for Attendant Counselors to refer to.</p> <p>All Nutritional Management Plans will be reviewed and updated as needed, starting with the three homes in which the sample residents live. The Occupational Therapist will in-service Attendant Counselors on cutting food into manageable bite size pieces. Attendant Counselors have been directed to cut food to manageable bite size pieces when food is not offered pre-cut. The Attendant Counselor Manager will work closely with the Occupational Therapist and Speech</p>	

*Abough*  
*5/18/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 460	<p>Continued From page 29</p> <p>his rate of in-take down. Feeding guidelines included small bites of food/drink. Staff were to make sure food was cut up into bite size pieces, including bread. Provide small amounts of liquids to reduce rate of drinking.</p> <p>Observation of breakfast on 03/10/14 revealed Resident #4 was given whole chicken nuggets. Resident #4 grabbed the pitcher of water and proceeded to fill up his water glass as he drank through his [REDACTED] while continuing to fill glass with water. Resident was able to drink half of the pitcher of water before staff entered the dining area and intervened. During this meal time staff failed to cut food, prompt resident to slow his rate of food and drink intake and provide small amounts of liquid as directed on dining guidelines</p> <p>Observation of dinner on 03/12/14 revealed Resident #4 was given whole chicken nuggets and tator tots (some mashed and some left whole). Resident was provided a glass of juice and 3 - 1/2 pint containers which included skim milk, 1% milk and chocolate milk. Resident was able to place one to two whole chicken nuggets in mouth and several tator tots, finishing meal within 2 minutes. Resident was able to drink all beverages within one minute, failing to use a [REDACTED]. During this meal time staff failed to cut food, prompt resident to slow his rate of food and drink intake, provide small amounts of liquid and provide a [REDACTED] as directed on dining guidelines.</p> <p>Resident #7: Review of Resident #7 dining guidelines revealed resident has [REDACTED] with reduced [REDACTED]. She eats and drinks with some spillage. She tends to take multiple bites before swallowing the previous bite. She is at mild to moderate risk for choking and aspiration. During the meal staff are to cut all</p>	W 460	<p>Therapist to assure that the Attendant Counselors have been trained on the dining scenario and have a clear understanding on how to safely supervise meals.</p> <p>A Meal Observation form will be used as a monitoring tool and has been revised to include the above topics. Copies of completed Meal Observation forms will be given to the DDA1 and Attendant Counselor Managers for review. Attendant Counselors will sign a training form indicating they have been trained and understand the above issues.</p> <p>Target Completion Date: 5/14/14 Person Responsible: PAT A Director</p>	

*Apayk  
5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 460	<p>Continued From page 30</p> <p>food to small bite size pieces. Cue her to chew and swallow food in her mouth. Avoid putting too much food on her plate.</p> <p>Review of Employee In-service Outline on Goals for Feeding revealed bite size pieces are ½ inch or approximately the size of your thumbnail. Observation on 03/12/14 revealed staff cut Turkey Wrap Hot dog into approximately 1 to 1 ½ inch pieces. Resident #7 was observed taking huge bites. During this meal time staff failed to cut food to appropriate bite size pieces and failed to cue resident during mealtime as directed on dining guidelines.</p> <p>Resident #25: Record review revealed Resident #25 was on a [REDACTED] with thin liquids. She had a Clinical Swallow evaluation on 12/10/13 that demonstrated she had oral motor problems including limited chewing, chewing with mouth open, rapid eating, pocketing food, and stealing food. Staff were to provide enhanced dining with verbal and physical cues to slow the rate of eating. Staff were to make sure that food was cut up into bite size pieces including bread. She was to have all her food cut up including canned fruit to ¼ inch size. Food was to be moistened with broth and she was to avoid sticky textures and to alternate liquids with food. Observation on 03/11/14 at dinner revealed Resident #25 grabbed 2 unmoistened bread rolls and quickly which she placed in her mouth. During this meal time staff failed to provide a [REDACTED] as directed on dining guidelines.</p> <p>Interview with Staff D revealed she was aware she had forgotten to cut up and moisten Resident #25 's bread before she ate it.</p> <p>Resident #26:</p>	W 460			

*Handwritten:*  
Hoyt  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 460	Continued From page 31 Record review revealed Resident #26 was a [REDACTED] with thin liquids. She had a Clinical Swallow evaluation on 03/13/13 that demonstrated moderate [REDACTED] with her having missing teeth, low tone, spillage, reduced tongue mobility with some thrusting, decreased lip seal on a cup, and uncoordinated delayed swallow. She takes large bites and eats rapidly and is distractible and vocalizes during meals and is a high risk for choking. Staff were to cue her to take small bites and all food was to be cut into bite sized pieces including bread. Observation during dinner meal on 03/ 11/14 revealed Resident #26 was served French fries which were not on her diet and were not cut into the bite size pieces. During this meal time staff failed provide a [REDACTED] as directed on dining guidelines.	W 460			
W 471	483.480(b)(1)(ii) MEAL SERVICES  Each client must receive meals with not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section.  This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 1 of 13 sampled residents (Resident #13) and 3 of 21 expanded sampled residents (Resident #16, 25 and 29) received the correct portion size for the diet prescribed. This failure placed residents at risk of receiving incorrect portions for diets prescribed, potentially causing a change in their overall health status.	W 471	Fircrest believes that each client receives meals with not less than 10 hours between breakfast and the evening meal of the same day but recognizes that the current version of Appendix J incorrectly lists the facility practice for W472, which is the appropriate quantity of food, under W471. New serving spoons have been ordered that will indicate the ounces of the food. Staff will be taught how to use the spoons to measure the required amount for each client. Clients who have no dietary restrictions related to portions will be allowed to have more food after the initial serving is eaten.		

*Abough*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 471	Continued From page 32  Findings include:  All observations, interviews, and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified. Observation revealed the facility main kitchen sends a diet slip with each meal which directs staff as to portion sizes prescribed by dietician. Observation of Unit 320 revealed staff assisting residents with serving unmeasured food portions (using an extra-large flat serving spoon) and failing to follow diet slip for dinner meal on 03/11/14. Resident #13: Review of dietary record revealed that Resident #13 was on a 1200 calorie, high fiber, and [REDACTED] due to decreased mobility. Observation on 03/11/14 of dinner meal revealed Resident #13 received several extra-large spoonful 's for the pureed turkey pot pie, one extra-large spoonful of biscuit (pudding consistency), one extra-large spoonful of ground peas and carrots and two extra-large spoonful 's of pureed bananas and oranges. When resident had completed her meal she had seconds on the turkey pot pie and fruit. Review of Resident #13 's dietary slip that came from the kitchen revealed that resident was to receive ½ cup of pureed turkey pot pie; 1 biscuit, ¼ cup ground peas and carrots and a ¼ cup of pureed bananas and oranges. Resident #16: Review of dietary record revealed that Resident #16 was on a [REDACTED] high fiber mechanical diet with nectar thick liquids. Observation on 03/11/14 of dinner meal revealed Resident #16 received one and a half extra-large	W 471	In order to assure that clients receive the correct portion of food, staff may have to spoon out the correct amount of food for some clients who are not able to correctly spoon out the identified amount of food. The client can then assist with the remaining part of serving the meal.  Attendant Counselor Managers (ACM) will conduct meal observations and check to see if staff are providing the correct amount of food and provide immediate feedback to staff. Duty office staff will also conduct observations and provide information to the ACMs on the observation.  Target Completion Date: 5/14/14 Person Responsible: PAT A Director	

*Handwritten:*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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)	(X6) COMPLETION DATE
W 471	<p>Continued From page 33</p> <p>spoonful ' s of pureed turkey pot pie, one extra-large spoonful of biscuit, one extra-large spoonful of peas and carrots and one extra-large spoonful of bananas and oranges.</p> <p>Review of Resident #16 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup ground peas and carrots, and ½ cup pureed bananas and oranges.</p> <p>Resident #25: Review of dietary record revealed that Resident #25 was on a 1600-1800 calorie [REDACTED]</p> <p>Observation on 03/11/14 of dinner meal revealed Resident #25 received two extra-large spoonful ' s of pureed turkey pot pie, two biscuits and one extra-large spoonful of pureed peas and carrots.</p> <p>Review of Resident #25 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup pureed peas and carrots, and ½ cup pureed bananas and oranges.</p> <p>Resident #29: Review of dietary record revealed that Resident #29 was on a [REDACTED] high fiber, [REDACTED] mechanical.</p> <p>Observation on 03/11/14 of dinner meal revealed Resident #29 received two extra-large spoonfuls of turkey pot pie, one and a half extra spoonful ' s of pureed biscuit, two extra-large spoonful ' s ' of peas and carrots and an individualized dessert from the kitchen that was already dished up.</p> <p>Review of Resident #29 ' s dietary slip that came from the kitchen revealed that resident was to receive 1 cup of pureed turkey pot pie, 1 biscuit, ½ cup ground peas and carrots, and ½ cup pureed bananas and oranges.</p> <p>Interview of Staff H, Staff I, and Staff J revealed they had worked with residents and knew how</p>	W 471		

*Handwritten:*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 471	Continued From page 34 much food each resident was to have and did not always use diet slips. However Staff D stated they did not have measuring utensils to measure the correct amount of food. Staff H, Staff I and Staff J stated they do encourage residents to serve themselves, however without measuring utensils it is difficult to gauge the accurate measurement of food portions.	W 471			
W 485	<b>483.480(d)(4) DINING AREAS AND SERVICE</b>  The facility must supervise and staff dining rooms adequately.  This STANDARD is not met as evidenced by: Observation and record reviews revealed the facility failed to ensure 1 of 13 sampled residents (Resident #4) and 1 of 21 expanded sampled residents (Resident #25) were adequately supervised and received needed interventions during meals. This failure placed residents at risk of compromised health including choking and or/aspiration.  Findings include:  All observations and record reviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.  Resident #4: Review of Resident #4 's dining guidelines revealed resident had [REDACTED] with open [REDACTED] He takes food, eats and drinks large amounts rapidly especially with favored foods. He is at moderate risk for choking and aspiration.	W 485	Dietary Department will assure that food is cut up into small, manageable bite size pieces for those clients with a Nutritional Management Plan requiring small pieces of food. The Occupational Therapist will provide a template to the Food Service Manager and Attendant Counselor Managers, showing the appropriate size food should be cut, as well as healthy serving size. The Food Service Manager will in turn provide this information to the Dietary staff. Attendant Counselor Managers will post the template diagram in dining rooms for Attendant Counselors to refer to.  All Nutritional Management Plans will be reviewed and updated as needed starting with the three homes in which the sample residents live. The Occupational Therapist will in-service Attendant Counselors on cutting food		

*rough*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  03/14/2014
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 485	<p>Continued From page 35</p> <p>Adaptive equipment included using a [redacted] for slow drinking. Management during meals included reminding him to put his fork/spoon down between bites and wait if he started to eat too fast; use gestures, physical prompts to slow his rate of in-take down. Feeding guidelines included small bites of food/drink. Provide small amounts of liquids to reduce rate of drinking. Observation of breakfast on 03/10/14 revealed Resident #4 was given whole chicken nuggets. Staff did not cut food as directed on dining guidelines. Resident was left unsupervised and placed one to two whole chicken nuggets in mouth. Resident #4 then grabbed the pitcher of water and proceeded to fill up his water glass as he drank through his [redacted] while continuing to fill glass with water. Resident was able to drink half of the pitcher of water before staff entered the dining area and intervened. Resident was left unsupervised at dining table for 7 minutes. Observation of dinner on 03/12/14 revealed Resident #4 was given whole chicken nuggets which staff failed to cut into bite size portions, and tator tots (some mashed and some left whole). Resident was also provided a glass of juice and 3 - ½ pint containers which included skim milk, 1% milk and chocolate milk. Resident was left unsupervised at dining table for 5-7 minutes and during that time he was able to place 1-2 whole chicken nuggets in his mouth. Resident ate his entire meal in less than 2 minutes. Resident was able to drink all beverages within one minute, failing to use a [redacted]</p> <p>Resident #25: Record review revealed Resident #25 was on a 1600-1800 calorie [redacted] with thin liquids. She had a Clinical Swallow evaluation on 12/11/13 completed by Speech Language Pathologist. Resident #25 demonstrated oral</p>	W 485	<p>to manageable bite size pieces. Attendant Counselors have been directed to cut food to manageable bite size pieces when food is not offered pre-cut. The Attendant Counselor Manager will work closely with the Occupational Therapist and Speech Therapist to assure that the Attendant Counselors have been trained on the dining scenario and have a clear understanding on how to safely supervise meals.</p> <p>A Meal Observation form will be used as a monitoring tool and has been revised to include the above topics. Copies of completed Meal Observation forms will be given to the DDA1 and Attendant Counselor Managers for review. Attendant Counselors will sign a training form indicating they have been trained and understand above issues.</p> <p>Target Completion Date: 5/14/14 Person Responsible: PAT A Director</p>	

*Amogh*  
5/16/14

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</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 485	Continued From page 36 motor problems including limited chewing, chewing with mouth open, rapid eating, pocketing food, and stealing food. Staff were to provide enhanced dining with verbal and physical cues to slow the rate of eating. Staff Instructions for Resident #25 's PBSP (12/10/13) revealed staff need to be next to resident during the entire meal. Staff were to provide verbal/physical cues to slow her rate of eating and to remind resident to swallow before taking the next bite. She is to be encouraged to place her fork down, and drink a few sips of water throughout the meal. Observation on 03/11/14 at dinner revealed two staff sitting with two 1:1 supervised residents, one staff member serving the residents and one staff member supervising six residents at the table. During this meal Resident #25 grabbed 2 bread rolls which she quickly placed in her mouth one at a time while staff member assisted another resident. Staff failed to notice resident grab the bread rolls and failed to intervene.	W 485			
W 488	483.480(d)(4) DINING AREAS AND SERVICE  The facility must assure that each client eats in a manner consistent with his or her developmental level.  This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each resident was provided an opportunity to promote independence with their dining experience on 6 of 18 units (Unit 307/308, 315/316 and 319/320). This failure did not allow residents the opportunity for skill development.  Findings include:	W 488	All PAT A staff providing support to client meals (AC and ATS staff) will be provided training on allowing for client learning and independence during meals. The only exception will be the dishing out of portions for clients who aren't able to learn this skill. Attendant Counselor Managers (ACM), Habilitation Plan Administrators (HPA) and the Developmental Disabilities Administrator 1 (DDA 1) will conduct meal observations and monitor for the promotion of independence. Immediate feedback		

*Apangh*  
*5/16/14*

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

PRINTED: 04/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  03/14/2014
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 488	<p>Continued From page 37.</p> <p>All observations, record reviews and interviews were completed on 03/10/14 through 03/14/14 unless otherwise specified.</p> <p>Observation at 06:45 am on 03/10/14 of unit 308 and 3:30 pm on 03/12/14 of Units 307/308 dining room revealed staff had set tables with napkins, drinking cups/glasses, and utensils.</p> <p>Observation at 06:30 am on 03/10/14 of Unit 315/316 dining rooms revealed staff had set the tables with drinking cups, utensils and napkins.</p> <p>Observation at 5:00 am on 03/10/14 of Unit 319/320 's dining rooms revealed tables were set with dicem (a mat that keeps plate from sliding on table), napkins, drinking cups/glasses, utensils, clothing protectors, and condiments. Plates were on the side table near the crockpots.</p> <p>Interview with Staff D revealed staff set the tables for every meal. The AC staff in charge of the meals were assigned duties to ensure the tables were set with everything except the plates or bowls. When asked why staff were setting tables Staff D stated this was the way it had always been done.</p> <p>Staff H stated during interview on 03/12/14 she does try to have residents assist setting the table, however either they refuse or when they are in dining room they want to eat right away and it is difficult for staff to get the meal ready in time.</p> <p>Record review revealed that per unit and Active Treatment Program Guidelines residents are to pick up their place settings (as able), find a seat at the table (as able) and serve themselves from bowls or trays with staff taking time to individually offer choices.</p>	W 488	<p>will be given to staff. Duty office staff will also conduct observations and provide information to the ACMs on the observation.</p> <p>Target Completion Date: 5/14/14 Person Responsible: PAT A Director</p>	

*Boyle*  
5/16/14