

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

PRINTED: 02/03/2016  
FORM APPROVED  
OMB NO. 0938-0391

RECEIVED

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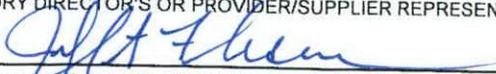
Residential Care Services  
ICF/IID Program

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>C</b> <b>12/16/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIRCREST SCHOOL PAT A</b>	STREET ADDRESS, CITY, STATE AND ZIP CODE <b>15230 15TH NORTHEAST D SEATTLE, WA 98155</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is a result of complaint investigation #3168820 conducted on 12/01/15 through 12/16/15 at Fircrest School PAT A. Failed provider practice was identified.</p> <p>The survey was conducted by: Shana Privett</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504</p> <p>Telephone: (360) 725-2405 483.420(d)(2) STAFF TREATMENT OF CLIENTS</p>	W 000	<p>W153</p> <p>The corrective actions the facility has taken or will accomplish for the sample individuals found to have been affected by the deficient practice: For Client 1: The facility will report all allegations of mistreatment, neglect or abuse as well as injuries of unknown source to the administrator or to other officials in accordance with state law through established practices. The QA HPA was in-serviced 12/01/2015 on required notifications in QA Directors absence. A new Incident and Event Reporting SOP was developed that outlines requirements of reporting. All staff will be trained on the new Incident/Event reporting SOP.</p>	
W 153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to report an allegation of abuse to Client #1 to the State Agency immediately following knowledge of the incident. Failure of the facility to report the incident in a timely manner prevented the State Agency from knowing what occurred and ensuring the client was safe.</p>	W 153	<p>The steps the facility has taken or will take to identify individuals who may be affected by the deficient practice, and the actions the facility has taken or will take to protect those individuals: For all other residents: All IR/event reports will be reviewed by the QA Director to ensure notifications have been sent as required, this will be monitored by the email distribution to the department and a newly assigned designee has been established to provide backup. Duty Office will receive specific training in regards to the requirements of after hours facility reporting by the Administration by 2/19/2016.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Superintendent</b>	(X6) DATE <b>2/12/16</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	<p>Continued From page 1</p> <p>This is a repeat citation from a recertification survey on 5/21/15.</p> <p>Findings include:</p> <p>Review on 12/4/15 at 9:45 AM of a Complaint Resolution Unit (CRU) report dated 12/1/15 revealed the facility was notified via a telephone call on 11/6/15 from Disability Rights of Washington (DRW) of an allegation of sexual assault to Client #1 that had taken place on 10/29/15.</p> <p>Review on 12/4/15 at 10:15 AM of the facility Special Investigative Unit (SIU) report dated 11/10/15 (conducted by Staff D) revealed a pending investigation on the incident had begun on 11/10/15 however the facility did not notify the Police or the State Agency. Staff D was unaware that the State Agency had not been notified until 12/1/15.</p> <p>Interview on 12/4/15 at 9:45 AM with Staff A and B verified that they had not notified the State Agency until 12/1/15, 25 days after the incident was initially reported to them. Staff A reported the police were not notified because the facility could not identify an alleged perpetrator.</p> <p>Interview on 12/4/15 at 11:00 AM with Staff C verified that he had notified the Duty Office of the incident on 11/6/15, however neither the State Agency nor the police were notified of the</p>	W 153	<p>The measures, including systemic changes, the facility has taken or will take to ensure that the deficient practice will not recur:</p> <p>All IR/Event Reports will be reviewed by the QA Director daily. A newly assigned designee has been developed to ensure that all notifications have been sent as required. If there is an omission located, the facility will make the appropriate notifications.</p> <p>The methods by which the facility will monitor the corrective actions to ensure the deficient practice is being corrected and will not recur:</p> <p>All IR/Event Reports will be reviewed by the QA Director or designee to ensure that all appropriate notifications have been made. These will also be reviewed by the PAT A core team at their weekly meetings and daily by the DDA for PAT as the copies are routed to the Program Area.</p> <p>Target Completion Date: 02/19/2016</p> <p>Person(s) responsible: PAT DDA, QIDDA, Assistant Superintendent</p>	

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W 153	Continued From page 2 incident. Staff C reported that Staff A and B notified the state agency on 12/1/15 when they discovered it had not been reported.	W 153		
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