| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 50G007 | A. BUILDING _____<br>B. WING _____ | C<br>04/09/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKELAND VILLAGE | S 2320 SALNAVE RD, PO BOX 200<br>MEDICAL LAKE, WA 99022 |

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| W 000 | INITIAL COMMENTS<br><br>This report is the result of a Complaint investigation (2785060/2784805) conducted at Lakeland Village on 04/09/13. A sample of one resident was selected.<br><br>The survey was conducted by:<br><br>[redacted] R.N., B.S.N.<br><br>The survey team is from:<br><br>ICF/IID Survey and Certification Program<br>Residential Care Services Division<br>Aging and Long-Term Support Administration<br>Department of Social and Health Services<br>P O Box 45600<br>Olympia, Washington 98504-5600<br><br>Telephone: 360-725-2405<br>Fax: 360-725-2642 | W 000 | | |
| W 127 | 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review the facility failed to protect 1 of 1 resident (Resident #1) from abuse during a behavior episode. Failure to protect resident from abuse resulted in physical injury to Resident #1.<br>Findings include: | W 127 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Diane M Kilgore | Acting Superintendent | 5/10/2013 |

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 127 | Continued From page 1<br>Review of facility Event/Incident Report dated 04/02/13 7:30 am, Preliminary Investigation Report dated 04/08/13, Behavior STAT Policy, Resident #1 ' s BSP (Behavior Support Plan) and IHP (Individual Habilitation Plan) revealed that Resident #1 requires 1:1 supervision (line of sight) at all times unless in his bedroom or bathroom and 2:1 supervision when on a van ride.<br>On 04/01/2013 Resident #1 and Staff A (who was 1:1 staff for resident) went to the laundry room to get a towel for Resident #1 ' s shower. While there Staff A left Resident #1 unattended while he went into the kitchen. While in laundry room Resident #1 noted there were some magazines in a box and wanted to read them. When Resident #1 left laundry room with the box of magazines, went into the kitchen and set the box of magazines on the counter. Staff A saw Resident #1 place the box of magazines on the counter and stated that Resident #1 was not allowed to have those kinds of magazines that were in the box. Resident immediately got upset. Staff A told Resident #1 he would speak with Staff B about the magazines. Staff B said the magazines were inappropriate kinds of magazines for resident. Resident #1 went to his bedroom and started throwing items around. Staff A stated resident became verbally and physically aggressive toward staff, hitting and spitting at them. Staff A reported that a physical hold was applied immediately and Resident #1 went to his bed and started thrashing, banging his head and hands on bedframe and wall.<br>Review of the facility Preliminary Report Resident #1 became very agitated and asked staff for his PRN medication (resident is [redacted] and able to ask for prn medication | W 127 | Plan of Correction<br><br>Tag 127, Related W Tag 154: the facility must have evidence that all alleged violations are thoroughly investigated. "Documentation revealed Staff A, B, C and D used excessive force in restraining resident causing injuries to his face, ear, neck, shoulder, and behind the ear". At the present the allegations have been investigated by local law enforcement (Spokane County Sheriff). The facility through the Superintendent further referred the allegation to Washington State Patrol. WSP has initiated its investigation, this investigation remains ongoing. WSP conduct several interviews of the accused staff on May 1st and 2nd 2013. At this time the allegations are being investigated as criminal in nature. Once the allegations are thoroughly investigated and dependent on the outcome appropriate legal action and or appropriate Just Cause actions will be applied. The facility will act according if another incident includes allegations of abuse/neglect. Appropriate investigative authorities, including local law enforcement, Washington State Patrol and finally the Special Investigations unit will be utilized to investigate the allegations. Once thorough investigation has occurred the materials/reports will be reviewed by the Superintendent who will then make decisions to addressing staff performance. At this time the staff are removed from client contact/off cottage. The facility promotes environments free of abuse neglect; this training begin with New Employee Training (8 days). All staff receives annual update trainings in mandatory reporting, positive interactions and graduated guidance. T.O refresher class is provided every two years and all other applicable training will be provided to staff that are deemed deficient in all areas of client care. Q/A is now reviewing all incident reports and monitoring for trends, and preventions plans. If the prevention plan is found to be inadequate in protecting the client the plan will be returned to the IDT for further development. PAT Director, DDA1, Superintendent will ensure corrections to this deficiency.<br><br>May 8, 2013 and ongoing. | |

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| W 127 | Continued From page 2<br>verbally). Resident #1 reported Staff A and B followed him into his bedroom and Staff B punched him repeatedly in the face and started to choke him. Resident #1 reported Staff A put his hands on his neck and said, " If you hit a girl again I ' m going to kill you myself. I can easily snap your neck. " Documentation revealed Staff A, B, C and D used excessive force in restraining resident causing injuries to his face, ear, neck, shoulder, and behind his ear.<br>Review of facility incident report revealed that Resident #1 had significant bruising to the left side of his face and a small laceration behind the left ear. Resident #1 was found to have 4 faint scratch-like marks on the left side of his neck and 3 marks that appeared to be finger prints on the left side of Resident #1 ' s throat. | W 127 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview facility failed to report to facility administrative staff and State Hotline allegation of abuse on 04/01/13 at 6pm until 04/02/13 at 7:30 am when 1 of 1 resident (Resident #1) was noted to have bruising to the left side of his face, ear, neck, shoulder, and abrasions behind the left ear. Failure to report prevented Resident #1 from receiving immediate medical assessments and treatments. Findings include: | W 153 | Tag W 153: The Staff involved in this behavior episode made records in both the CUR progress notes and on Behavior Recording Forms (BRF). The nurse that administered the STAT medication also recorded on the medication admission record (MAR), behavior recording form (BRF) and progress notes. At this time the staff involved did not recognize or chart any injuries. The injuries went unnoticed during the night shift; staff check each client who is sleeping by opening their door in order to recognize that the client is not in medical distress. Lights are not utilized to verify client condition as this is very intrusive to sleeping clients. The injuries to client #1 were first noticed by AM shift on April 2, 2013. The incident report was initiated and medical attention was provided by the facility ARNP. This incident continues to be investigated by Washington State Patrol WSP and the results will dictate the facility's direction.<br><br>May 8, 2013 and ongoing. | |

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| W 153 | Continued From page 3<br>On 04/02/13 7:30 am, Staff G reported when he walked over to where Resident #1 was standing at the counter talking with shift staff, Staff G noticed left side of Resident #1 ' s face was swollen from his eyebrow to jaw and discoloration around left eye and down left side of neck to shoulder on the left side. Bruising was purple/blue in color indicating bruising was new.<br>Review of Facility Event/Incident Report and Preliminary Investigation Report revealed that staff from 2nd shift, 3rd shift, and Licensed Nurse failed to report the incident to management staff and failed to document in Resident #1 ' s file on 04/01/13.<br>Review of Resident #1 ' s file revealed no documentation that reflected resident had bruising present from evening, night, or morning staff before 04/02/13 at 7:30 am. | W 153 | The facility will train staff to visually inspect each client/resident for sign and symptoms of injury following any physical hold for 24 hours each hour. If tissue damage is revealed, staff will notify the assigned nurse for assessment. The nurse will then complete an acute nursing care plan for continued monitoring. The staff who identifies injury will initiate the Incident Report and record in progress notes. This directive will apply to all three shifts. Injuries will be brought to the attention of the PAT Director/Superintendent for additional follow up actions.<br><br>May 31, 2013 and ongoing.<br><br>All staff will be directed to follow the directives contained in DDA 5.15 and LV 3.4 G. No physical holds will be applied to clients/residents in a prone or supine position on the floor or on another suspended device for example bed or couch.<br><br>May 8, 2013 and ongoing. | |
| W 186 | 483.430(d)(1-2) DIRECT CARE STAFF<br><br>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews facility failed to provide sufficient staffing for 3 of 3 residents (Resident #1, 2, and 3) as stated in their Individual Habilitation Plans (IHP) and Behavioral Support Plans (BSP). Failure to ensure sufficient staffing left Resident #1, #2, and #3 at risk of harm.<br>Findings include: | W 186 | Tag W 186: All staff will be reminded to follow the one to one guidelines and to summon additional support by utilizing the Behavior STAT procedure LV 4.9 B. Superintendent will write an all staff memo and deliver by electronic mail directing that staff follow the one to one supervising guidelines. In order to provide the least restrict environment IDT will review all 1:1 requirements and make any adjustments appropriate for clients while on cottage.<br><br>May 8, 2013 and ongoing. | |

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| W 186 | Continued From page 4<br>Interview with management and record review of CIM Preliminary Report revealed Resident #1 had gone to laundry room with his 1:1 staffing on 04/01/13 to get supplies for his shower. 1:1 staff (Staff A) left Resident #1unsupervised when Staff A went to the kitchen area. Staff A would not have been able to see Resident #1 in the laundry room. Resident #1 is to have 1:1 staffing within line of sight during waking hours unless in his bedroom or bathroom.<br>Record review and interview revealed that Resident #2 and #3 were left unattended in the living room of the facility when their 1:1 staff were in Resident #1 ' s bedroom during the behavior. Resident #2 and #3 require 1:1 staffing when not in their bedroom or bathroom. Both residents were left alone in the living room with no staff present to supervise them.<br>Staff A, B, C, and D did not call for assistance through their Behavior STAT protocol which left Resident #2 and #3 unprotected during a period of approximately 10 minutes while they were in Resident #1 ' s room assisting Staff A. | W 186 | | |
| W 227 | 483.440(c)(4) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interviews the facility failed to ensure that staff followed Resident #1 ' s IHP. Failure to follow the IHP led to staff not implementing least restrictive restraint measures. | W 227 | Tag W 227: Staff A during his regular course of duty on 84-85 Sunrise left John Nelson without line of sight supervision briefly. John was unsupervised in the laundry area retrieving his bathing items. During this momentary break in supervision John Nelson found magazines that were deemed inappropriate for his viewing by the IDT. ACM and Psychologist are redefining 1:1 supervision guidelines while on the cottage, that said the magazines in question should not have been readily accessible to client #1 within the cottage/bathing supply/laundry area. The ACM will remove graphic magazines from the cottage.<br><br>May 8, 2013 and ongoing. | |

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| W 227 | Continued From page 5<br>Findings include:<br>Record review of Resident #1 ' s BSP notes that for Self Injurious Behaviors (SIB) staff are to follow a four step process starting with Step 1: Verbal Prompt/Medical Treatment; Step 2: Neutral Area; Step 3: Physical Hold; Step 5: STAT medication. Resident #1 had gone to the laundry room with 1:1 staff to get his supplies for showering. The 1:1 staff left the area and left Resident #1 alone and unattended by any staff member. Resident #1 found a box of magazines in laundry room and went to take them when staff intervened and told resident he could not have those magazines (abridgements not listed in IHP or BSP related to resident not having access to magazines) and put them back. Resident #1 became angry and went to his room and started having behavior by throwing items in his room. Per documentation in Resident #1 ' s Interdisciplinary Notes, resident " went to his room and became very upset, throwing objects around the room as well as being physically aggressive hitting and spitting at staff. " Documentation in the CIM Preliminary report states that Resident #1 asked for his PRN medication and staff did not follow through with getting for him as his behaviors had improved by that time; however documentation in the interdisciplinary notes further explains that " staff ran BSP and spent time calming client down. Medication nurse was notified for STAT medication. " Resident has orders for two STAT Medications. They are as follows:<br>· STAT Criteria #1: Resident #1 approaches staff requests a " prn " because he is feeling unsettled/agitated/upset/[redacted]/et al. ([redacted] 500mg and [redacted]e 50mg Q4 hours as needed) | W 227 | Abridgments are found the graphic section of CUR. The HPA's will provide information into the IHP/NPS section regarding abridgements. The facility will ensure compliance during the Annual IHP; the HPA's will be given an expectation that all client right issues will be addressed in the IHP under the NPS section. A copy of the abridgement will be placed in the graphic section with the original filed in our records department. The Q/A assigned HPA representative will ask each HPA for a sample of documentation of NPS addressing abridgements for restriction and provide this information at the monthly Q/A meeting.<br><br>May 31, 2013 and ongoing.<br><br>At this time it is premature to determine whether STAT medication was delivered after John's request. John was assessed and STAT medication was given by nursing per documentation in the BRF and progress notes. The event on the evening 04/01/2013 is currently under investigation by Washington State Patrol (WSP). At this time the facility has removed the four staff from client contact involved in this incident. Pending the outcome of the investigation appropriate just cause actions will apply. | |

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| W 227 | Continued From page 6<br>· STAT Criteria #2: Resident has met criteria and is assessed by medical/nursing staff to meet the criteria ([redacted] ([redacted] 1mg) :<br>o Behavioral symptoms/criteria for medical assessment: Medical assessment is indicated when resident continues to escalate despite use of positive supports and displays two or more of the following behaviors:<br>§ Pacing<br>§ Muttering to self<br>§ Makes statements about father being present<br>§ Changes from normal gait to aggressive posture (shoulders forward, more left to right movement in walk)<br>§ Scowl on face<br>§ Increase in accusations towards peers<br>Medical assessment is also indicated when aggressive, self-injurious or destructive behaviors emerge suddenly (without escalation symptoms listed above), and:<br>· Behavior continues to present a danger to self, others, or property<br><br>Review of Preliminary 5-day Investigation Report by Complaint Investigation Manager (CIM) completed on 04/08/13 revealed Resident #1 had a " behavior " episode where he was allegedly physically and verbally aggressive, when staff intervened they put him in a restrictive hold. Per Resident #1 ' s BSP " the use of a physical hold is only to be used as a last resort. The goal is to not lay hands on Resident #1 if it can be at all avoided. Resident #1 has a neutral area as a Step for several of his problems. This is only to be used if appropriate to the situation and Resident #1 refuses to go to a quiet area to use his coping skills. " | W 227 | | |
| W 275 | 483.450(b)(1) MGMT OF INAPPROPRIATE | W 275 | | |

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| W 275 | Continued From page 7<br>CLIENT BEHAVIOR<br><br>Policies and procedures that govern the management of inappropriate client behavior must be consistent with the provisions of paragraph (a) of this section.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure staff implemented facility approved interventions for 3 of 3 residents ' (Resident #1, 2, and 3). Failure resulted in actual and/or physical harm to one resident (Resident #1) and placed two other residents (Resident #2 and 3) at risk of harm.<br>Findings include:<br>Review of Resident #1 ' s record revealed Diagnosis of [redacted] with [redacted] and [redacted] by [redacted]r. Resident #1 ' s Behavioral Support Plan (BSP) dated 10/23/12, identifies specific approaches for staff to follow in the event of the resident becoming verbally or physically aggressive. For aggression these steps include deflect/redirect, neutral area, physical hold, and STAT medication. For SIB these steps include verbal prompt/medical treatment, neutral area, physical hold, and STAT medication. For [redacted]Ideations/Attempts these steps include verbally prompt/prevention strategies/outlet area, verbally prompt the uses of prevention strategies, disengage conversation, 1-2 person body restraint/arm control restraint, complete a lethality report, and STAT medication. | W 275 | Tag W 275: The Superintendent has issued an all outlook user notification on May 3, 2013 indicating that Staff are to follow 1:1 supervision guidelines and to utilize the behavior STAT process in procedure 4.9B, to summons assistance for behavior challenges. This is also available on the LV share point site under Superintendent directives. At this time alleged allegation are being thoroughly investigated by Washington State Patrol. Pending the outcome of the investigation appropriate just cause actions will apply. PAT/Director and DDA 1 will provide and In-service training staff development emphasizing the utilization of the Behavior STAT procedure to the ACMS. ACMS will provide the same training/staff development opportunities to their assigned staff this will occur by May 31, 2013. DDA 1 will continue to provide post critic of all Behavior STATS. | |

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| W 275 | Continued From page 8<br>For Property Destruction these steps include deflect/redirect neutral area, physical hold, and STAT medication. For unsupported departures these steps include interrupt/redirect. For [redacted] staff are to interrupt/redirect and for [redacted] social behavior the steps are to deflect/redirect.<br>Review of Resident #1 ' s file revealed that on 04/01/13 at 6:00 pm Resident #1 became upset, entered his bedroom and began throwing items. Staff A stated in the 5-day Preliminary Investigation Report that Resident #1 was very resistant, kicking, hitting, biting, and slamming head into wall trying to get away from staff after being placed in a physical hold on his bed. A Behavioral STAT was not called by staff per facility policy.<br>Review of facility policy for a Behavior STAT reveals that the STAT notification system will be used to summon assistance during a behavioral crisis and in response to a protective need.<br>Record review and interview revealed that facility did not initiate a STAT at the time of Resident #1 was having behaviors.<br>Resident #2 and #3 were left unattended while their 1:1 staff were in Resident #1 ' s bedroom during the behavior incident leaving residents at risk of harming themselves/others or potentially eloping due to not having 1:1 staff in place. | W 275 | | |