No Excuses
Shining a light on abuse and neglect of people with developmental disabilities in Washington’s institutions

July 2017
A Letter from the Executive Director

Dear Reader,

People with disabilities are abused and neglected every day across Washington. That does not mean it should be tolerated. Every person should be safe in their own home, no matter who they are or where they live. No excuses.

Abuse can happen anywhere, but it is particularly disturbing when it occurs in a place specifically designed for the purpose of providing a safe place to receive treatment. Washington’s Residential Habilitation Centers are run by our state government to serve people with developmental disabilities. These institutions have a track record of seriously harming and neglecting their residents.

This report is a catalogue of failures and tragedies that occurred in our state-run institutions in the single calendar year of 2016. You will read that people who expected to be safe in their homes choked to death, were sexually assaulted, nearly drowned, suffered from medication errors, and were denied the very treatment they moved to the facility to get. And these are just some of the awful wrongs that were reported to, and corroborated by, state investigators during that time. There is no way to know how many other
abuses happen when investigators are not present. There can be no excuse for the travesties described in this report, and no excuse for tolerating more of the same in the future. We cannot allow people with developmental disabilities to be abused, neglected, isolated, and ignored.

We must all actively work to end abuse and neglect. It does not happen on its own. It was abuse and neglect in state institutions that motivated Congress to create a network of protection and advocacy agencies across the country in 1975, and Disability Rights Washington has served as our state’s protection and advocacy agency for more than 40 years. This gives us the power to show the public what problems exist, as we did in this report, but our federal authority does not provide us the power to make the system change. It is up to the public – that is, each one of us – to demand better from our government that runs these facilities and force them to change their ways.

While reading this report is disturbing, I hope it motivates you to act. If it does, please email facilities@dr-wa.org to let us know what you are doing to help in this fight and find out how you can coordinate with others who are standing up for change.

Sincerely,

Mark Stroh
Executive Director
Disability Rights Washington
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Introduction

In Washington, over 800 people with developmental disabilities live in four state-run institutions called Residential Habilitation Centers (RHCs). People living in institutions have sacrificed a life in the community for assurances of safety and the supports to provide them with meaningful skill building activities. However, according to dozens of reports from 2016 that Disability Rights Washington reviewed, the people in these facilities are subjected to conditions that fall below minimum standards for safety and clinical support. In just the past calendar year, failures at these institutions have left at least one person dead, at least two people sexually assaulted, and others seriously harmed or nearly dead.
The State is responsible for surveying these institutions to determine whether or not each institution meets federal standards for operation. Under these standards, at least two basic conditions must be met: people must be safe and people must receive appropriate treatment. Washington is failing on both fronts. The State’s own surveyors have found that people living in these state-run institutions are in danger and the list of potential harm is long: sexual assault, choking, malnourishment, a lack of medical care, and even death. Simultaneously, people living in Washington’s institutions are being denied the skills training that these facilities exist to provide.

This harm is preventable. The circumstances that led to the choking death of one man were not isolated. Similarly, the lack of supervision that led to the near drowning of another man can be seen in hundreds of pages of surveys across all four RHCs. After a staff person sexually assaulted a woman one day, the same staff again assaulted another woman the following day.

“No Excuses” sheds light on the pattern of unsafe conditions and lack of treatment in Washington’s RHCs, as identified in the State’s own surveys. While most of this information is publically available, it is apparent that the ongoing problems are not widely known nor discussed. This report synthesizes a single year’s worth of information to call attention to the serious harm that continues to occur. These systemic failures endanger people with developmental disabilities in all of the RHCs and cannot continue, as there are no excuses for these failures.
Background

Disability Rights Washington

Each state and territory has an independent advocacy organization with a federal mandate to ensure the rights of people with disabilities are protected and they are not abused or neglected. In Washington, Disability Rights Washington is that organization as it has been designated Washington’s Protection and Advocacy System by the governor.4

This report was created by Disability Rights Washington’s Treatment Facilities Program, which focuses on the delivery of services to people receiving services in institutionally-based residential facilities that generally serve 16 or more individuals. The Treatment Facilities Program advocates for the effective delivery of treatment in humane and therapeutic conditions.

Residential Habilitation Centers

Washington operates the following four institutions for people with developmental disabilities5:
Safety and well-being

Being safe in your own home is the most basic expectation any human being has. Each person who moved into an RHC to meet his or her support needs has that same basic expectation of safety. RHC staff are required to develop and implement procedures that protect residents from all forms of abuse, neglect or mistreatment. Additionally, RHCs must be kept clean, structurally maintained and compliant with safety codes. People living in RHCs also have the reasonable expectation that they will receive legally required adequate and appropriate medical care. A person’s medical needs and methods for meeting those needs should be integrated into an individualized plan developed for each person.
Active treatment to achieve highest level of ability

Washington’s RHCs exist to support individuals in achieving their highest level of abilities through a comprehensive educational program known as active treatment. Each person living in an RHC must receive active treatment.9 Active treatment is a program that includes specialized training, treatment, and health services to help each person with a developmental disability to live with as much self-determination and independence as possible.10 It also means the RHC should actively prevent the regression or loss of a person’s current or optimal function.11 For example, if a man in an RHC does not know how to brush his teeth, staff members would help him to learn how to brush his teeth so that he could eventually brush them himself, rather than simply brushing his teeth for him.
Oversight authority

The Washington State Department of Social and Health Services’ (DSHS) Developmental Disabilities Administration oversees the operation of services to meet the needs of people with developmental disabilities. This includes privately and publicly run, institutional and community based services for people with developmental disabilities. The Developmental Disabilities Administration directly runs Washington’s four RHCs, which are licensed as nursing facilities and/or intermediate care facilities. People living in both of these types of facilities expect and are legally entitled to get 24 hour supervision, medical services, and active treatment.

The Centers for Medicare & Medicaid Services (CMS) is part of the federal government’s Department of Health and Human Services, and is responsible for ensuring state compliance with federal statutory and regulatory requirements for state facilities. Each state conducts inspection and investigation surveys on behalf of CMS. In Washington, Residential Care Services (RCS) conducts required inspections and surveys on behalf of CMS to license and certify long-term care facilities, including RHCs.

Generally, RCS submits a “Statement of Deficiencies” to a facility if a federal requirement, called a condition of participation, is not met. The facility responds with a “Plan of Correction” to address each and every deficiency. If the facility does not fix the unlawful conditions of care, RCS will send a letter to notify the facility of an enforcement action including a denial of payment or an admission freeze. RCS conducts surveys of the RHCs at least every 15 months.
Purpose and scope

The purpose of this report is to describe the harm that people with developmental disabilities experience in Washington’s state-run RHCs in one document, and to call state leadership to action. People with developmental disabilities often face dangerous conditions and endure neglect in these institutions. Disability Rights Washington learned of these ongoing problems, in part, through its review of surveys that are publicly available online, and through receipt of enforcement letters that RCS disseminates. While most of this information is readily available, it is apparent that the ongoing unsafe environment and lack of active treatment are not widely known nor discussed. This report is intended to facilitate a critical discussion about the most effective methods and conditions for serving people with developmental disabilities.

The information in this report is limited to the 2016 calendar year to illustrate the conditions of care and scope of problems found at these institutions. There are references to additional events outside of 2016 to explain reoccurring issues and patterns. The examples contained in this report do not include all of the findings from the state-run institutions in 2016; instead, the report highlights some of the most significant findings from RCS’s 2016 surveys.

Methodology

The problems contained in this report are pulled directly from the surveys and findings of RCS, the office responsible for surveying and licensing long-term care facilities that the State directly operates, including the RHCs. This report includes additional information from news accounts, state policies, and federal and state law to provide context and explanation of the RCS findings.
People with developmental disabilities are being hurt in Washington’s Residential Habilitation Centers

People who live in Washington’s state-run institutions have an expectation and right to be safe and free from abuse and neglect. Washington directly operates these facilities and, consequently, has direct responsibility for what happens to the people in their care. However, the State’s own RCS surveys reveal that the people who rely on institutions have suffered serious harm, and – in at least one instance – lost life. In 2016, employees working in state-run RHCs reported:

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<tr>
<th>Allegations of Injury of Unknown Origin</th>
<th>Accident Allegations</th>
<th>Restraints / Seclusion Allegations</th>
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<td>257</td>
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People have died, been sexually assaulted, and nearly drowned

Personal safety is a minimal and basic expectation of residents of the RHCs. To provide this, staff of the RHCs are legally responsible for creating and implementing plans to keep people safe. The failure to do so has led to abuse, neglect, and mistreatment of residents.
Choking

It is not uncommon for people with developmental disabilities to have difficulty swallowing. Therefore, it is quite common for institutions serving people with developmental disabilities to provide modified diets as well as in-person assistance and supervision when people are eating to help them avoid choking. Unfortunately, Washington’s state-run institutions have been cited repeatedly for failing to follow such plans and these repeated failures have resulted in deaths.

“Two men living at Rainier choked to death almost exactly one year apart.”

Two men living at Rainier choked to death almost exactly one year apart. In August 2015, six residents with individualized dietary protocols related to food preparation went to a park for lunch with two staff members. One man with a developmental disability needed sandwiches to be crust-less and cut into half-inch pieces to reduce the risk of choking. His dietary plan also required a staff member to check to make sure that his mouth was clear before each bite, and to remind him to take small bites.22

However, during his lunch at the park, staff gave the man a peanut butter and jelly sandwich with the crust still on and without cutting it into the required one-half inch pieces. He tried to eat the sandwich quickly, filling his mouth with the sandwich. He choked and died at the scene. No evidence was found to indicate that this resident had any supervision after the sandwich was provided to him, or that staff attempted to ensure his mouth was clear before taking a bite, as required by his plan.23
Immediately following the incident, off-campus trips were suspended, and the procedures for all off-campus trips were revised to include eating protocols. Staff members were trained on the diet/eating protocol for each resident, and were to be informed on an ongoing basis of any changes made to an individual’s protocol.24

Almost a year later to the day of the 2015 choking death, in August 2016, another man choked to death on a hot dog during Rainier’s annual summer event.25 To keep him safe, he had dietary restrictions in his individualized plan. His plan stated “[s]andwiches needed to be cut into [nine] pieces to reduce the possibility of choking.” The plan even identified that “[h]is life was saved in 2005 when he choked on a sandwich … ” The plan did not specifically indicate that meat needed to be cut into one inch pieces as well, or how it would be implemented across settings. The facility failed to provide clear and comprehensive directions to staff about how his food should be prepared to

A care provider bulletin on choking and how to prevent choking posted inside of a Lakeland Village cottage.
prevent choking. As a result of Rainier’s failure, this man ate a hotdog, choked on it, and died.  

These were not the only people at risk of choking at Rainier, and Rainier is not the only facility serving people with choking issues. As an example, a man living at Fircrest needs a thickening agent added to any liquid he drinks because he is at high risk of choking and aspiration. This requirement is clearly set forth in his individualized plan. However, RCS found that in the short time its surveyors were present, the man was observed thirteen different times in the span of two days drinking liquids without thickening agent. With continuing violations like these, it is just a matter of time before another person dies due to facility staff not following prescribed dietary plans.

**Near drowning**

Rainier staffs’ lack of supervision continued to endanger people when just twelve days after the 2016 choking death, a man nearly drowned after his staff left him unattended on the edge of a dock. During what should have been a fun trip to the lake, staff parked the man strapped in his wheelchair on the dock without a lifejacket. Rainier had documentation that he had a habit of leaning and tilting his chair to propel it forward. In light of this knowledge, he was still left on the edge of the dock, in a wheelchair in which the brakes did not securely lock due to extensive tire damage. He tipped the chair over and fell off the dock and into the water. The wheelchair submerged under water while the man was strapped into it, unable to free himself.
Three different staff members jumped into the water to try to pull the man out, but he was fully submerged under water and still restrained into the chair for over a minute, possibly two minutes. Where staff were unsuccessful, a bystander responded and was able to cut the man free. Upon further investigation, RCS discovered that the resident’s admission assessment stated that he liked to rock back and forth to move his wheelchair, but Rainier failed to specify how close someone needed to be to supervise the man. Rainier had no policies or procedures that directed the staff on how to protect clients on or near the water, nor did the facility have policies that directed the staff on how to respond to an emergency related to outings involving water. Rainier did not ensure that staff provided for this man’s safety when it was known that he could move his wheelchair.30
RCS conducted a survey following this event and issued an enforcement letter finding immediate jeopardy to Rainier’s residents. While Rainier addressed the immediate jeopardy, RCS found continuing violations of federal law through subsequent observations and required the facility to provide a plan to ensure residents will be protected in future situations.31

**Self-harm**

Individuals sometimes use self-harming behaviors when they experience emotional pain, intense anger and frustration, but lack a better way to respond to or express their feelings.32 This is the type of behavior a facility would address in an individualized plan to help keep the individual resident with this behavior safe. RCS found one woman was not protected from harm, despite the facility being fully aware she engaged in self-injurious behavior.
At a local hospital, a woman living at Fircrest was observed with cuts on her inner thighs. A written report reviewed by RCS revealed that she told hospital staff that she inflicted the injuries with a knife. She told the hospital staff that she still had possession of the knife, which was in her purse in her bedroom at Fircrest. Her purse was found, with the knife in it, where she said she had left it. This is particularly troubling given that her current individualized behavior plan written approximately five months earlier clearly described her struggles with self-injurious behavior. The resident’s plan specifically set forth how to help her stay safe, including a requirement that “at the start of each shift, [staff] do a quick check of her bedroom area and remove any item from her room that she could use to harm herself or possibly ingest.” Either the plan was insufficient or it was not properly executed by staff. What is most troubling though, is that it appears Fircrest did not care as RCS found that Fircrest did not conduct any interviews to determine how the woman was able to get the knife and keep it in her bedroom following the discovery of her wounds.

**Malnourished**

A man with a developmental disability living at Lakeland Village had a restrictive diet plan in an attempt to manage his desire to stay in his room. The plan called for staff to only provide diet supplements if he came out of his room. However, this restrictive plan failed to ensure that he would get proper nutrition because it contained no instructions if and when the individual wanted or needed to stay in his bedroom. While one direct care staff raised concerns about the program with the team, the concern was dismissed. RCS found that the Lakeland Village staff implemented a restrictive diet for behavior management without accounting for potential negative effects on the man’s health and in turn, put him at risk of weight loss.
**Staff sleeping on duty**

A Rainer staff member was literally sleeping on the job. At the time, this staff member was assigned to supervise a resident who needed in-sight supervision 24 hours, seven days per week. Nine different staff people were aware of this incident of neglect, but none of them reported it immediately, as required. Instead, it took thirteen days for staff to report the neglect to RCS. Upon further investigation, staff reported to RCS that this staff person was found sleeping “75% of the time he checked on her” while assigned to a resident who needed one-on-one supervision.
Sexual assault

On the heels of the most recent choking death and the near drowning at Rainier, RCS discovered that not only were Rainier staffs’ inaction causing serious harm, but so were one staff member’s intentional acts. On November 14, 2016, RCS received a complaint alleging that a staff member sexually assaulted a female resident the day before. The resident was taken to a nearby hospital and received a full exam and rape kit. Later that day, RCS received another complaint indicating that the same staff member had sexually assaulted a second resident. An RCS investigation later identified two additional residents who received direct care by the staff member as potential sexual assault victims. One potential victim received “treats” and “extra showers” from the staff member.39

Further investigation by RCS in the following week revealed that Rainier had not instituted protective measures in response to the initial complaint. RCS interviewed several staff members who verified that no training had been given to identify sexual trauma in adults with developmental disabilities. For example, staff had not been trained to recognize how a person who is non-verbal may communicate that they had been sexually assaulted.40

The survey does not go into the details of these sexual assaults, but RCS makes several conclusions based on its own record review, observation, and interviews. RCS found that Rainier failed to: ensure that residents were free from abuse, identify other potential victims, provide victims with psychological care and treatment, and take protective measures for other potential victims.41
RCS conducted a survey following the sexual assaults and issued an enforcement letter finding immediate jeopardy to residents. Through a subsequent survey, RCS found continuing violations of federal law and required the facility to ensure residents will be protected in the future.

Mental abuse

While these incidents of sexual abuse occurred at Rainier, residents at other facilities face other forms of abuse. For example, two staff members witnessed a third staff member mentally abuse a Fircrest resident. Much like RCS found when it investigated the sexual assaults at Rainier, RCS found that Fircrest staff compounded the harm caused by the abuse when neither of the staff who witnessed the abuse immediately reported it. The abuse was not communicated to any other staff or reported for over 24 hours later. Although staff members were aware of the abuse, Fircrest took no actions to protect the resident during that time.

People are not getting proper medical care

An integral part of ensuring the safety and well-being of individuals is to provide proper medical care. However, RCS has found that people with developmental disabilities living in the RHCs are not getting appropriate and necessary medical care. This failure puts people’s lives in danger.

Unlicensed nurses

RCS found that five nurses had expired licenses at the time of its October 2016 survey at Lakeland Village. These five nurses were not removed from their responsibilities to care for residents when their licenses expired. Additionally,
the facility was not aware that these nurses had expired licenses until it was alerted by RCS.45

Medication errors

Errors when providing a person with their medications can be harmful to their health, and a mistake could even lead to death. A Yakima Valley resident was given the wrong medication nine times. According to the resident’s charts, staff noticed she was not responding to stimuli, her arms were limp and she was slow to blink, but her vitals were within acceptable range. This increased sleepiness and lethargy continued over the next two days with staff ultimately noting that she had been sleeping for the majority of 24 hours, yet was still lethargic. Finally, the nurse ordered for her evening medication dose to be held. An RCS investigation revealed that the woman’s medication card had an incorrect label, and she had been given the wrong medication. Based on the survey, it appears that RCS discovered the medication error through their
investigation. RCS concluded that the facility lacked the necessary procedures to protect residents from medication errors in both the on-site pharmacy’s dispensing and staff’s receiving of medication.46

Conversely, at Lakeland Village Nursing Facility a resident was given half of their prescribed and required medication. Staff did not discover the error until the next day. One week later, the same staff person made the same error again. During an RCS investigative interview, staff confirmed that the facility did not initiate a timely investigation to determine what led to the errors.47

A medication cart inside a Lakeland Village cottage.

Lack of CPR

A person was found unresponsive by a staff member at Rainier. Instead of initiating cardiopulmonary resuscitation (CPR) as policy required, the staff called a second staff member. Then, this second staff person decided to consult a third staff member. The third staff person involved told the staff person who
still had not begun CPR to call a fourth staff member. Over the phone, the fourth staff person told the person standing near the resident, who was still unresponsive, to call 911, but did not suggest to start CPR because she “assumed this was already occurring per policy.”

At this point, four different staff people knew of the unresponsive resident, but the resident still had not received CPR. An emergency crew arrived and began CPR. The emergency crew confirmed that three staff members were all at the scene when they arrived, and no one was doing CPR on the resident. During an RCS investigation, a female Rainier staff member verified that staff had not followed policy, and that she “was unable to determine a good reason for why the policy was not followed by staff.”

“The emergency crew confirmed that three staff members were all at the scene when they arrived, and no one was doing CPR on the resident.”

Summary

Individuals live in these facilities so that they can receive appropriate treatment and services in a safe place. However, as RCS has repeatedly identified, staff are endangering the safety of the people with disabilities in their care. As shown above, the State, through RCS, has cited itself on numerous occasions over the last year. They failed to prevent the foreseeable choking that killed a man. They denied a man nutrition when he did not behave as they wanted. They failed to supervise a man and as a result, he nearly drowned. They slept on the job. They failed to prevent the sexual assault of at least two residents. They failed to provide medical care. And on several occasions, they failed to take appropriate remedial measures when harm was discovered.
Washington’s Residential Habilitation Centers are not providing disability-related services

Besides needing staff to keep them safe, the people who live in RHCs are also supposed to receive services to help them become more independent. In order for residents of RHCs to work towards living independently, RHCs need to teach basic skills such as how to communicate with others or feed or bathe oneself. These services, generally called “active treatment,” are provided by assessing individuals’ abilities and skills, then creating and implementing written plans to improve those abilities and skills. Without these plans, staff cannot provide treatment. The failure to deliver these services is comparable to working at a college, but never providing an education. In effect, the individuals are merely warehoused while the institution holding them receives federal and state money.

A sign on a wall in Rainier reads, “Active Treatments means Always Teaching.”
According to federal laws, RHCs must provide active treatment, which is defined as:

a continuous … program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services … that is directed toward … [t]he acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible.50

RCS’ surveys identify the systemic failure to provide active treatment across three of the four RHCs. The surveys identified at least 13 violations at these institutions regarding the failure to provide active treatment in the 2016 calendar year. Additionally, RCS cited the institutions for at least 28 violations involving individual program plans.51

**Lack of skills training**

RCS observed a man with a developmental disability for three days at Rainier, and found that the facility repeatedly failed to ensure that he had opportunities to receive training to become more independent. They watched as he sat for several hours without doing anything. For long periods of time staff did not interact with him or suggest activities, and when they did, it was around an activity he already knew how to do. In the woodshop, he spent his time in the breakroom with his head laying on the table in front of him.52
During the same three days visit, RCS observed a woman at Rainier trying to play a game of bingo with some other residents. She did not know how to play, but staff did not provide her with any help to learn. The woman moved to a nearby window to stare outside, where she remained without any intervention or training from staff. The following day, RCS observed the same woman, in what was supposed to be an art class, drawing circles over and over by herself. There were no skills training offered to her during an observation period of over two hours that day.

At Fircrest in August 2016, a woman with a vision impairment tried to walk from one room to another while using a walker to assist her. RCS watched her as she struggled to find her way, continuously bumping into walls, furniture and other residents until staff finally guided her to the dining room for a meal. Once the woman made it to the table to sit down, a staff person set food
in front of her, but did not tell the woman what was placed in front of her. After several minutes of waving her hand around the table to find her glass, she gave up.\textsuperscript{55}

The next morning, RCS observed the same woman as she attempted again to navigate the house with her walker. She again bumped into walls and furniture. She began to scream out of frustration. Instead of taking the training opportunity to help the woman navigate in her own home, a staff member guided her outside to the patio where she sat down. RCS found that there were no staff qualified that could develop the plans to deliver blind training.\textsuperscript{56}

In November 2016, RCS continued to find a lack of active treatment at Fircrest. During random periods of observation over a week, they saw that staff members repeatedly failed to provide a man with active treatment. RCS watched the man sitting and standing alone while staring idly into the open room or floor. No staff members spoke to him or encouraged him to try an activity. They saw the man again, two days later, but this time he was sitting next to a paper shredder. He was expected to sit and shred sheets of paper. While staff cued him to continue shredding when he would stop, no one gave the man any training or instructions. Again, RCS found that Fircrest was not providing residents with every opportunity to receive training that would help them become more independent as the facility is both funded and required by law to do.\textsuperscript{57}

**Not following treatment plans**

Individuals reside at RHCs for the specific purpose of getting the supports and training they need to gain as much independence as possible. The institutions are supposed to develop plans for each person to do this.
However, the mere existence of these plans is insufficient; staff must follow the plan, document the individual’s progress, and modify the plan as necessary. This plan is called an Individual Habilitation Plan. However, when RCS conducted a random observation of several residents at Lakeland Village during a four-day period, it found that Lakeland Village staff did not implement the residents’ Individual Habilitation Plans.

For example, RCS observed a woman who needed instruction to be able to eat more independently. Her Individual Habilitation Plan provides instructions to build these skills while eating. Specifically, she is supposed to touch utensils and use her napkin while dining, but staff wiped her mouth and never cued her to touch anything during the entire meal. Staff explained that they make few demands of her because she yells loudly and disturbs other residents when they do. However, they acknowledged that
they should be implementing her Individual Habilitation Plan to help her gain independence.\(^6\) Another Lakeland Village resident’s Individual Habilitation Plan clearly stated that the individual needed to be encouraged to take sips of liquid. Instead, the resident drank three large glasses of juice, each in one continuous gulp, without any staff intervention to encourage taking sips. His plan also required that he stay on the grass behind the building instead of traveling on the road. However, he was seen walking between parked cars and on the service road. Upon further RCS investigation as to why no staff members did not follow his Individual Habilitation Plan, staff responded by saying that the he is a “very difficult [c]lient to work with and he had been left alone by staff for many years to prevent behavioral outbursts.”\(^6\)

RCS found similar, persistent failures at Rainier.\(^6\) A man living at Rainier needed training to learn to eat and drink independently. His individualized plan specifically called for staff members to encourage independent meal

A sign on a Rainier resident’s door that reads “I am going to focus on controlling my emotions. I will practice controlling myself and not having outbursts.”
choice and preparation to build the skills necessary to reach his goals. Instead, staff asked him if he wanted a snack, and then proceeded to break up a breakfast bar into a bowl and pour orange juice over it without asking what the man wanted to eat. When the man finished eating the concoction, a staff member picked up the dishes, rather than using the opportunity to help the man clean up the bowl himself. This happened again the following night when staff gave him dinner in which he was not involved in the choice, set-up, preparation or serving of the meal.63

**Chemical restraints**

Instead of developing and following adequate plans to address behavioral concerns of several residents, Lakeland Village uses chemical restraints. Chemical restraints are drugs used to sedate someone to manage behaviors.64 RCS found that the Lakeland Village allowed staff to use emergency chemical restraints for nine of eleven Lakeland Village residents in one random sample and two of thirteen in another sample. As required by law, drugs are only to be used as an “integral part of a client’s individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.”65 RCS found that Lakeland Village violated these requirements when it allowed for the planned use of medications to manage behaviors in resident’s plans.66

**Summary**

People with developmental disabilities reside in these institutions so that they can obtain the skills they need to live more independently. These facilities are funded to do this and designed for this sole purpose.67 Instead, residents sit alone day after day without staff providing proper training. Compounding the harm of being denied opportunities to gain new skills,
some people are given drugs to manage behaviors the staff want them to stop, rather than staff working with them to acquire new, more helpful, behaviors.

Conclusion

This report presents a mere snapshot of the conditions in Washington’s state-run RHCs. It highlights only some of the failures that the State’s own RCS identified in its surveys over the past year. Remarkably, the moments of staff neglect—leaving residents without services and attention—occurred during the few days a year when RCS was on-site and observing a few select people. Often, RCS found repeat violations from other surveys. It is impossible to know how many more violations happened during the hundreds of days and nights when RCS was not around, or how the hundreds of people whom RCS does not meet are being treated.

An empty wheelchair sits outside of a Lakeland Village cottage.
These failures are not new. For example, Fircrest, Rainier and Lakeland Village all received a denial of payment for new admissions in the 2015 calendar year. In each instance, RCS determined that the facility was out of compliance with federal law regarding minimum standards, including failures to protect clients and provide active treatment.68

The lack of care in these RHCs results from systemic neglect of people with developmental disabilities. In 2016 alone, foreseeable and documented conditions led to the death of at least one man, the sexual assault of at least two people, and many others were at risk of serious harm or death. Appropriate medical and skill building care was not provided to countless people while they were isolated in these institutions. In many cases when abuse was discovered, sustainable measures were not taken to prevent future abuse. All the while, people who are being harmed are not receiving the skills training that they live in RHCs to receive.
Abuse and neglect of vulnerable persons must stop. We can all agree on that. The safety of people living in RHCs is a persistent problem. It is also a fundamental concern for the developmental disabilities community. This community recognizes its responsibility to see the end of abuse wherever it occurs, and this report makes it clear that neglect and abuse are unacceptably common in Washington’s institutions. The persistent unsafe and substandard therapeutic conditions are inexcusable and must stop.

Disability Rights Washington calls for the convening of a group of individuals with disabilities, their family members, guardians, friends, advocates, and state officials and policymakers. This group should identify the systemic root causes of abuse and neglect of people in our State’s institutions, and then identify and implement solutions. These solutions must ensure that the women and men in these institutions are safe and get the full benefit of the services they deserve.
About the Author

Reisha Abolofia is a staff attorney on Disability Rights Washington’s Treatment Facilities Program. Reisha advocates for the effective delivery of treatment in humane and therapeutic conditions for people with disabilities in facilities. She received a Bachelor of Arts from the University of Washington in 2009 and a Juris Doctor from Gonzaga University School of Law in 2014.
End Notes


2 Under Washington State law, the RHCs were established to provide individuals with developmental disabilities “residential care designed to develop their individual capacities to their optimum” and “to insure a comprehensive program for the education, guidance, care, treatment, and rehabilitation of all persons admitted to residential habilitation centers.” RCW 71A.20.010.

3 See generally 42 U.S.C. § 1396d(d); 42 U.S.C. § 1396r; 42 C.F.R. §§ 483.1- 483.160; 42 C.F.R. §§ 483.400-483.480. Additionally, as recognized by the legislature, no matter where people live, they have a right to live free from abuse and neglect. See generally RCW 74.34.005.


6 See 42 C.F.R. § 483.12(a), (b); 42 C.F.R. § 483.420(a)(5).

7 See generally 42 C.F.R. § 483.90; 42 C.F.R. § 483.470.

8 See 42 C.F.R. § 483.25; 42 C.F.R. § 483.430(a).
Residents have a right to active treatment in both ICFs and NFs. CMS regulations require that nursing facilities provide specialized services to people with developmental disabilities who need continuous supervision, treatment and training. “Specialized services means the services specified by the State which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of [active treatment provided in ICFs].” 42 C.F.R. § 483.120. Federal courts confirmed that residents of these facilities have an entitlement to adequate, habilitative treatment equal to ICF level of care, even when in a NF. See, e.g., Rolland v. Romney, 318 F.3d 42, at 57 (1st Cir. 2003) (“states [must] …provide specialized services in such a manner as to constitute active treatment.”); see also Rolland v. Patrick, 483 F. Supp. 2d 107 (D. Mass. 2007) (holding active treatment means the same thing for qualified individuals whether in a NF, ICF or a community-based program).


See Survey & Certification - General Information, Centers for Medicare & Medicaid Serv., https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html (last modified Nov. 15, 2013, 3:10 PM) (stating “CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers […] The survey (inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies. The functions the States perform for CMS under the agreements in Section 1864 of the Social Security Act (the Act) are referred to collectively as the certification process.”).

See Residential Care Services, Aging and Long-Term Support Admin., Washington State Dep’t of Soc. and Health Serv., https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services (last visited May 25, 2017) (stating “RCS is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and certified community residential services and supports.”).


DSHS archives each RCS survey for the public to view on their website. Both public and private run intermediate care facilities (including the RHCS) are listed on the “ICF/IID Locator” page. Each facility references contact information and an option to “View Reports.” This page can be accessed at https://fortress.wa.gov/dshs/adsaapps/lookup/ICFIIDLookup.aspx. Nursing facilities have a separate “Nursing Home Locator” page where a search option allows one to search for a location or nursing facility. This page can be accessed at https://fortress.wa.gov/dshs/adsaapps/lookup/NHPubLookup.aspx. By searching for a facility, a person can access contact information for each facility and view reports. Disability Rights Washington compiled, reviewed and synthesized all of the RCS’s findings from the 2016 surveys available on both of these websites for this report.

See 42 C.F.R. § 483.12; 42 C.F.R. § 483.420.

Top 10 allegations for ICF/IIDs CY 2016, State Run ICF/IIDs CY 2016; data collected by Washington State Dep’t of Soc. and Health Serv., Residential Care Services Division using ICF/IID Citation Log and provided to DRW (May 16, 2017).

RCS Statement of Deficiencies (hereinafter “SOD”) and Plan of Correction (hereinafter “POC”) for survey dated 2/19/2016, Rainier PAT A (finding violation W149 citing 42 C.F.R. § 483.420(d)(1)), attached as Exhibit 1, pages 8-16.

RCS SOD and POC for survey dated 2/19/2016, Rainier PAT A (finding violation W149 citing 42 C.F.R. § 483.420(d)(1)), attached as Exhibit 1, page 8-16.

RCS SOD and POC for survey dated 2/19/2016, Rainier PAT A (finding violation W149 citing 42 C.F.R. § 483.420(d)(1)), attached as Exhibit 1, page 8-16.


RCS SOD and POC for survey dated 10/28/2016, Rainier PAT C (finding violation W240 citing 42 C.F.R. § 483.440(c)(6)(i)), attached as Exhibit 2, pages 1, 2.


As DSHS and other care providers have long known, aspiration is one of the leading causes of death among individuals with developmental disabilities. See Aspiration/Pneumonia
29 RCS SOD and POC for survey dated 8/31/2016, Rainier PAT E (finding violation W104 citing 42 C.F.R. § 483.410(a)(1)), attached as Exhibit 4, pages 2-6.
30 RCS SOD and POC for survey dated 8/31/2016, Rainier PAT E (finding violation W104 citing 42 C.F.R. § 483.410(a)(1)), attached as Exhibit 4, pages 2-6.
31 Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, Residential Care Services, to Administrator/Superintendent, Rainier School PAT E (Sept. 21, 2016) attached as Exhibit 5.
32 Self-injury/cutting, Overview, Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/self-injury/home/ovc-20165425 (last visited June 12, 2017) (defining self-harm as “[n]onsuicidal self-injury, often simply called self-injury, is the act of deliberately harming the surface of your own body, such as cutting or burning yourself. It’s typically not meant as a suicide attempt. Rather, this type of self-injury is an unhealthy way to cope with emotional pain, intense anger and frustration.”).
33 RCS SOD and POC for survey dated 8/26/2016, Fircrest PAT A (finding violation W154 citing 42 C.F.R. § 483.420(d)(3)), attached as Exhibit 6, pages 10, 11
34 RCS SOD and POC for survey dated 8/26/2016, Fircrest PAT A (finding violation W154 citing 42 C.F.R. § 483.420(d)(3)), attached as Exhibit 6, pages 10, 11.
39 RCS SOD and POC for survey dated 12/13/2016, Rainier PAT C (finding violation W127 citing 42 C.F.R. § 483.420(a)(5)), attached as Exhibit 9, pages 2-10.
40 RCS SOD and POC for survey dated 12/13/2016, Rainier PAT C (finding violation W127 citing 42 C.F.R. § 483.420(a)(5)), attached as Exhibit 9, pages 2-10.
41 RCS SOD and POC for survey dated 12/13/2016, Rainier PAT C (finding violation W122 citing 42 C.F.R. § 483.420), attached as Exhibit 9, pages 1, 2.
42 Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, Residential Care Services, to Administrator/Superintendent, Rainier School PAT C (Nov. 28, 2016), attached as Exhibit 10.
43 Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, Residential Care Services, to Administrator/Superintendent, Rainier School PAT C (Dec. 20, 2016) attached as Exhibit 11 (letter sent to Rainier regarding RCS's post-visit describes the timeline of events related to the previous complaint investigations).

44 RCS SOD and POC for survey dated 11/22/2016, Fircrest PAT N (finding violation F226 citing 42 C.F.R. § 483.13(c)), attached as Exhibit 12, pages 2, 3.

45 RCS SOD and POC for survey dated 10/21/2016, Lakeland Village (finding violation W170 citing 42 C.F.R. § 483.430(b)(5)), attached as Exhibit 13, pages 2-6.

46 RCS SOD and POC for survey dated 2/16/2016, Yakima Valley (finding violation of F425 citing 42 C.F.R. § 483.60(a), (b)), attached as Exhibit 14, pages 1-6.

47 RCS SOD and POC for survey dated 6/16/2016, Lakeland Village Nursing Facility (finding violation of F333 citing 42 C.F.R. § 483.25(m)(2)), attached as Exhibit 15, pages 2, 3.

48 RCS SOD and POC for survey dated 2/26/2016, Rainier PAT A (finding violation W149 citing 42 C.F.R. § 483.420(d)(1)), attached as Exhibit 16, pages 1, 2 (survey findings state that staff failed to provide emergency care until the ERT or Community Emergency Team instructed otherwise as required by Standard Operating Procedure 2.13).


50 42 C.F.R. § 483.440(a)(1); supra note 12.

51 Top 10 citations for ICF/IIDs CY 2016, State Run ICF/IIDs CY 2016; data collected by Washington State Dep’t of Soc. and Health Serv., Residential Care Services Division using ICF/IID Citation Log and provided to DRW (May 16, 2017).

52 RCS SOD and POC for survey dated 9/23/2016, Rainier PAT E (finding violation W196 citing 42 C.F.R. § 483.440(a)(1)), attached as Exhibit 17, pages 13-15 (indicating that this is a repeat citation from the Recertification Survey of July 15, 2016).


55 RCS SOD and POC for survey dated 8/26/2016, Fircrest PAT A (finding violation W206 citing 42 C.F.R. § 483.440(c)(1)), attached as Exhibit 6, pages 29-34.

56 RCS SOD and POC for survey dated 8/26/2016, Fircrest PAT A (finding violation W206 citing 42 C.F.R. § 483.440(c)(1)), attached as Exhibit 6, pages 29-34.


58 See 42 C.F.R. § 483.440.

Washington State Department of Social and Health Services (DSHS), (2015), slide 52
https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/PASRR%20Webinar%20to
%20Distribute.pdf (explaining that in nursing facilities plans of care must incorporate
recommendations for, and ensure implementation of, specialized services).

60 RCS SOD and POC for survey dated 3/4/2016, Lakeland Village (finding violation W249 citing
42 C.F.R. § 483.440(d)(1)), attached as Exhibit 19, pages 1-3.
61 RCS SOD and POC for survey dated 3/4/2016, Lakeland Village (finding violation W249 citing
42 C.F.R. § 483.440(d)(1)), attached as Exhibit 19, pages 4-5.

62 RCS SOD and POC for survey dated 9/23/2016, Rainier PAT E (finding violations of W247
citing 42 C.F.R. § 483.440(c)(6)(vi)), W249 citing 42 C.F.R. § 483.440(d)(1), W250 citing 42 C.F.R. §
483.440(d)(2), and W255 citing 42 C.F.R. § 483.440(f)(1)(i)), attached as Exhibit 17, pages 25-38
(finding that the Individual Habilitation Plan did not include opportunities for client choice
and self-management, and finding repeated violations since the July 15, 2016 survey for
failure to implement, monitor and change programs).
63 RCS SOD and POC for survey dated 9/23/2016, Rainier PAT E (finding violation W247 citing
42 C.F.R. § 483.440(c)(6)(vi)), attached as Exhibit 17, page 25-27.
64 See Policy 5.15, Use of Restrictive Procedures, Developmental Disabilities Admin. Policy
Manual, Washington State Dep’t of Soc. and Health Serv. (May 2016), at page 2,
65 42 C.F.R. § 483.450(e)(2).
66 RCS SOD and POC for survey dated 3/23/2016, Lakeland Village (finding violation W312
citing 42 C.F.R. § 483.450(e)(2)), attached as Exhibit 20, page 16-21.

67 Under Washington State law, the RHCs were established to provide individuals with
developmental disabilities “residential care designed to develop their individual capacities to
their optimum” and “to insure a comprehensive program for the education, guidance, care,
treatment, and rehabilitation of all persons admitted to residential habilitation centers.” RCW
71A.20.010.
68 Letter from Loida Baniqued, Field Manager, ICF/IID Survey and Certification Program, RCS,
to Anthony DiBartolo, Superintendent, Lakeland Village (Mar. 27, 2015, amended Mar. 30,
2015), attached as Exhibit 21; letter from Gerald Heilinger, Field Manager, ICF/IID Survey and
Certification Program, RCS, to Jeff Flesner, Administrator/Superintendent, Fircrest School (July
29, 2015), attached as Exhibit 22; letter from Loida Baniqued, Field Manager, ICF/IID Survey
and Certification Program, RCS, to Harvey Perez, Superintendent, Rainier School PAT A (May 8,
2015), attached as Exhibit 23.

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