Exhibit 6
This report is a result of complaint investigation #3449296 at Rainier School PAT A on 10/04/17. Citations were written. The Condition of Participation for Governing Body, W102, was cited and Regulations at W104, W186, and W249 were cited. An Immediate Jeopardy was determined. The facility put a protection plan in place immediately to remove the risk of ongoing potential for harm to Client #1.

The survey was conducted by:
Patrice Perry

The survey team is from:
Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, ICF/IID Survey and Certification Program
PC Box 45600, MS: 45600
Olympia, WA 98504

This CONDITION is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure the safety of one Sample Client (Client #1) when the Client had a fourth incident of eating food outside of his prescribed diet texture with the past five months.
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<tr>
<th>W 102</th>
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<td>Client #1 was not provided the supervision required based on the facility assessment of his needs in two of these incidents. The number of staff assigned to the house and how they were deployed put other Clients at risk of not having proper supervision and ensuring their safety and needs could be met. This failure placed Client #1 at risk for choking, aspiration and potentially death. The failure also put other Clients at risk of harm or needs being unmet because of lack of proper supervision, as identified by the facility.</td>
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<td>This citation resulted in the finding of an Immediate Jeopardy.</td>
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<td>Findings included:</td>
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<td>See W104, W186 and W249 for details</td>
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| W 104  | The governing body must exercise general policy, budget, and operating direction over the facility. |
|        | This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure there were sufficient staff at Klamath House to provide the needed supervision for one Sample Client (Client #1) to prevent repeated incidents of him eating food outside of his prescribed diet texture. The facility failed to ensure staff were deployed in a manner which would meet all of the Clients' needs who resided there. The facility failed to ensure staff followed infection control measures per the facility Standard Operating Procedures (SOP) and the Individual Habilitation Plan (IHP) |
W 104 Continued From page 2

for Client #1. This failure put Client #1 at risk for aspiration pneumonia, choking, and potentially death. This failure put all Clients residing at Klamath House at risk for not having their care provided for as written in their IHP, and the failure put staff at risk for contracting an infectious disease.

Findings included:

Review of facility investigations for Client #1 showed he had previous incidents of ingesting items outside of his prescribed diet texture that had been reported for investigation of regulatory compliance. The facility investigated an incident on 05/04/17 involving Client #1, and their conclusion was that Client #1 ate _____ when staff failed to provide the required protective supervision (PRO), line of sight. An incident, dated 08/14/17, was investigated by the facility and they concluded that Client #1 obtained _____ when he was out of his room unsupervised, and staffing at the house was two staff under basic staffing levels at the time of the incident. The conclusion also identified Client #1 had _____ and was at high risk for aspiration and a pureed diet (food that has been altered to a soft, smooth paste consistency) was required. The most recent reported incident, dated 08/24/17, was related to Client #1 obtaining _____ and was found with crumbled bread in front of him, however, the facility chose not to investigate the incident because they had begun a trial of decreasing his supervision during the time frame of the reported incident.

While entering Klamath House on 10/04/17 at
Continued From page 3

9:30 AM (to investigate two prior reported incidents of Client #1 eating food outside his prescribed diet texture while unsupervised). Client #1 was observed by the surveyor standing in the kitchen holding three pieces of half eaten wheat bread. Client #1 was eating the remaining pieces of bread. No staff were present in the kitchen at the time of the incident. At approximately 9:31 AM, Staff A, Direct Care Staff, (DCS) entered the kitchen. She stated “You aren’t supposed to have that.” and attempted to remove the food from his mouth with her bare hands.

Record review of Client #1’s Physician Dietary Order, dated 07/13/17, showed his diet as a pureed texture.

Record review of Client #1’s Positive Behavior Support Plan (PBSP), dated 02/09/17, identified attempted consumption of foods outside of prescribed diet as an inappropriate behavior being addressed. Prevention procedures outlined in the PBSP included PRO supervision, defined as the Client will be within the line of sight of staff, up to 10 feet away, in order to react quickly if he attempted to eat food outside of his diet texture whenever he was out of his bedroom. The PBSP also identified the following instructions if he was eating food outside his prescribed diet texture: tell him no and attempt to make eye contact, monitor for choking, do not put fingers in his mouth unless he is unconscious, ask him to spit it out and report to the nurse if he swallowed the food.

Record review of Client #1’s 90-Day Health Care Assessment, dated 08/22/17, showed Client #1 was a

Record review of the facility SOP 4.21 state that
Continued From page 4

Standard Precautions was a concept that all human blood and bodily fluids are to be handled as if infected with blood borne pathogens. SOP 4.22 stated that Standard Precautions require gloves to be worn when touching mucous membranes (like the lining of a mouth).

Record review of the Facility Communication Sheet for Klamath house on 10/04/17 showed the house was understaffed by one staff member for day shift that day.

During interviews on 10/04/17 at approximately 9:34 AM and 9:42 AM, Staff A, Direct Care Staff (DCS) stated that she had gone on break leaving Staff B alone at the house to care for seven Clients, including Client #1 who required PRO supervision when out of his bedroom. The current incident of eating food outside of his prescribed diet occurred when Staff B was at the house. Later she stated that Staff B was left alone at the house to care for seven Clients and that Staff B was not aware of the supervisory need of Client #1 at the time of the incident.

Observation on 10/04/17 at 9:46 AM showed Staff B left with one Client once again leaving one Staff with six Clients, including Client #1. This recreated the staffing scenario observed at 9:30 AM when Client #1 was unsupervised and ate food not according to his prescribed diet.

During an interview on 10/04/17 at 11:57 AM, Staff D, Attendant Counselor Manager, stated that Client #1 required line of sight supervision while outside of his bedroom and three of the six Clients at the house at 9:50 AM required line of sight supervision in the bathroom. She also stated the house was short one staff member for
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>W 104</td>
<td>Continued From page 5 the day shift.</td>
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<td>W 186</td>
<td>483.430(d)(1-2) DIRECT CARE STAFF</td>
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The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

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.

This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure sufficient staff were available to implement the Individual Habilitation Plan for one Sample Client (Client #1) when Client #1 was unsupervised in the kitchen and ate food outside of his prescribed dietary texture, and to also potentially meet the needs of the other six Clients at Klamath House at the time of the incident. This failure placed Client #1 at risk for choking, aspiration pneumonia, and potentially death, and the other Clients at risk for harm and not having their needs met.

This is a repeat citation from the Recertification Survey completed 05/31/17.

Findings included:

Observation at Klamath House on 10/04/17 at 9:30 AM showed Client #1 standing in the kitchen eating bread. No staff were present.

Record review of Client #1's Physician Dietary Order, dated 07/13/17, showed his diet as a pureed texture (food that has been altered to a
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| W 186 | Continued From page 6  
soft, smooth paste consistency).  
Record review of Client #1’s Positive Behavior Support Plan (PBSP), dated 02/09/17, identified attempted consumption of foods outside of prescribed diet as an inappropriate behavior being addressed. Prevention procedures outlined in the PBSP include protective supervision (PRO), defined as the Client will be within the line of sight of staff, up to 10 feet away, in order to react quickly if he attempted to eat food outside of his diet texture whenever he was out of his bedroom. The PBSP also identified the following instructions if he was eating food outside his prescribed diet texture: tell him no and attempt to make eye contact, monitor for choking, do not put fingers in his mouth unless he is unconscious, ask him to spit it out and report to the nurse if he swallowed the food.  
Record review of the Facility Staff Communication Sheet, dated 10/04/17, showed six staff assigned for 12 Clients at Klamath House for the day shift. It showed Client #2 left at 8:45 AM on a scheduled off campus trip with two staff, and a Client went to the barber shop at 8:45 AM with one staff, leaving two staff to care for seven Clients.  
During interviews on 10/04/17 at approximately 9:34 AM, 9:42 AM, and 9:50 AM Staff A, Direct Care Staff (DCS) stated that she had gone on break leaving Staff B alone at the house to care for seven Clients, including Client #1 who required PRO supervision when out of his bedroom. The current incident of eating food outside of his prescribed diet occurred when Staff B was at the house. Later she stated that Staff B was left alone at the house to care for seven
## W 186

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Clients and that Staff B was not aware of the supervisory need of Client #1 at the time of the incident. She stated that she was the only staff member at the house with six Clients, including Client #1, #3, #4 and #5 to care for at 9:50 AM.

During an interview on 10/04/17 at 11:57 AM, Staff D, Attendant Counselor Manager, stated that the house was working short and when questioned what staff would be expected to do if they were alone with Clients, including Client #1 and he left the house she stated "They would call me." She stated that Clients #3, #4 and #5 required staff to remain in line of sight in the bathroom and Client #1 required PRO while out of his bedroom.

## W 249

483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:

- Based on observation, record review, and interview the facility failed to implement the Individual Habilitation Plan (IHP) as written for one Sample Client (Client #1) when he consumed food not within his dietary texture restrictions, was unsupervised around food and staff put their ungloved fingers in his mouth. This failure placed
W 249 Continued From page 8

Client #1 at risk for harm from choking, aspiration pneumonia, and potentially death. It also placed staff at risk for contracting a blood borne infection.

Findings included:

Observation at Klamath House on 10/04/17 at 9:30 AM showed Client #1 standing in the kitchen eating bread. No staff were present. At approximately 9:31 AM, Staff A, Direct Care Staff (DCS), entered the kitchen. She stated “You aren’t supposed to have that.” and attempted to remove the food from his mouth with her bare hands.

Record review of Client #1’s Physician Dietary Order, dated 07/13/17, showed his diet as a pureed texture (food that has been altered to a soft, smooth paste consistency).

Record review of Client #1’s Positive Behavior Support Plan (PBSP), dated 02/09/17, identified attempted consumption of foods outside of his prescribed diet as an inappropriate behavior being addressed. Prevention procedures outlined in the PBSP include protective supervision (PRO), defined as the Client will be within the line of sight of staff, up to 10 feet away, in order to react quickly if he attempted to eat food outside of his diet texture whenever he was out of his bedroom. The PBSP also identified the following instructions if he was eating food outside his prescribed diet texture: tell him no and attempt to make eye contact, monitor for choking, do not put fingers in his mouth unless he is unconscious, ask him to spit it out and report to the nurse if he swallowed the food.
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<td>W 249</td>
<td>Continued From page 9</td>
<td>Record review of Client #1's 90-Day Health Care Assessment, dated 08/22/17, stated Client #1 was [redacted]. Record review of Client #1's IHP dated 02/09/17 showed that staff were to use Standard Precautions per Standard Operating Procedure #4.22 due to Client #1 being [redacted]. Record review of facility SOP 4.21 and 4.22 stated that Standard Precautions require gloves to be worn when touching mucous membranes (like the lining of a mouth). During an interview on 10/04/17 at 9:42 AM, Staff A, DCS, stated that Staff B, DCS, did not know Client #1 required line of sight supervision while out of his bedroom.</td>
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