Exhibit 8
**W 000 INITIAL COMMENTS**

This report is a result of investigative complaints #3312465, #3316149, #3312276, #3310399 and #3302810 at Rainier School Pat A. Failed provider practice was identified and citations were written.

The survey was conducted by:
Patrice Perry

The survey team is from:
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Aging & Long Term Support Administration
Residential Care Services, ICF/IID Survey and Certification Program
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Olympia, WA 98504

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**W 111 CLIENT RECORDS**

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by:
- Based on record reviews and interviews the facility failed to ensure there was an accurate medical record for two of two Sample Clients (Client #1 and #2). This failure placed Clients at risk of inadequate/inappropriate treatment of medical conditions.

Findings Included:
### Client #1

Record review on 01/25/17 of Client #1's file showed he was readmitted to the facility from the hospital on 11/16. The facility readmission skin assessment (titled Body Part Diagram) dated 11/16 showed "see note Re: [redacted]." The progress note dated 11/9/16 showed "Stage II breakdown to [redacted] without measurement, identification of type of wound or description of the wound. Client #1 was re-hospitalized on 11/16 and returned to the facility on 11/15/16. The readmission skin assessment dated 11/9/16 showed Client #1 had a "pressure wound" on his [redacted] without measurement or description of the wound on the assessment. The progress notes dated 11/15/16 did not address the wound in regards to interventions, the size of the wound, treatment of the wound or whether the doctor was aware of the wound.

During an interview on 01/25/17 at 11:40 AM, Staff A, Registered Nurse (RN), stated that the facility does not routinely measure wounds nor do they have a protocol for monitoring healing/deterioration of wounds or how to categorize a wound.

During an interview on 01/26/17 at 9:30 AM, Staff B, RN, verified the facility does not have a policy or procedure to identify pressure ulcers or to monitor skin conditions. Staff B stated each individual house at the facility has their own Primary Care Nurse responsible for care of Clients and they are responsible for the development of the nursing care plan.
Continued From page 2

Record review on 02/08/17 of the Facility 5-Day Investigation Report (from a reported complaint) for Client #1 dated 02/16/17 revealed Staff A, RN, reported Client #1 has a "chronic skin condition" and "does not have a pressure sore". This description was not consistent with the documentation in the file.

Record review on 02/08/17 of Client #1's file showed a physician progress note, dated 12/12/16, stated "Here to evaluate [redacted] on [redacted] Was [redacted] on 11/19/16 now it has progressed to [redacted]. This was not consistent with the 5 Day Investigation description of the wound.

Client #2

Record review on 02/08/17 of Client #2's file showed he died on 02/17.

Record review on 03/14/2017 of Client #2's file showed a routine medical re-evaluation with vital signs and a physical assessment documented that was signed and dated 01/31/17 by Staff G, Physician.

During an interview on 03/21/17 at 11:45 AM, Staff G, Physician stated that he was unsure why the form was signed and dated 10 days after the Client had died.

W 149

483.420(d)(1) STAFF TREATMENT OF CLIENTS

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.
W 149 Continued From page 3

This STANDARD is not met as evidenced by:
Based on record review and interviews the facility failed to provide services to prevent harm for one of one Sample Clients (Client #1) when interventions were not ordered or implemented for an identified skin issue upon return from the hospital. This failure prevented Client #1 from receiving needed care and placed the Client at risk for infection, worsening of skin condition, increase in pain and increased risk of returning to the hospital from complications related to the wound.

Findings included:

Record review on 01/26/17 of Client #1’s file showed the facility readmission skin assessment (titled Body Part Diagram) dated 1/16 revealed “see note Re: [redacted] The progress note dated 11/09/17 showed [redacted] breakdown to [redacted] without measurement, identification of type of wound or description of the wound. The Treatment Administration Record (TAR) for November 2016 had no treatment ordered/identified for Client #1’s wound from 11/09/16-11/12/16. Interdisciplinary Progress Notes dated 11/09/17 identified “[redacted] breakdown to [redacted]...order written” however no order for treatment was found in Client #1’s chart.

In an email communication on 02/26/17 to the surveyor, Staff A, Registered Nurse (RN), stated that she could not verify whether or not treatment had been ordered for Client #1’s [redacted] wound from 11/09/16-11/12/16.

During an interview on 03/21/17 Staff G, Physician, stated that zinc was ordered when Client #1 was seen in the clinic on 11/10/16 and...
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>W 149</td>
<td></td>
<td>Continued From page 4 an order was found in the chart dated 11/09/16 with instructions for [REDACTED] to [REDACTED] QID (four times a day) x (times) 7 days. Record review on 01/26/17 of Client #1’s Physician’s orders showed there was no order dated 11/09/16 at that time. Record review on 03/22/17 of the completed 5-Day Investigation Report for Client #1, dated 02/16/17 did not identify the order dated 11/09/16 for [REDACTED] and the order was not reflected on the Treatment Administration Record.</td>
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<td>W 154</td>
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<td>STAFF TREATMENT OF CLIENTS 483.420(d)(3)</td>
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<td>The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to thoroughly investigate an incident of potential neglect for one of one Sample Clients (Client #1). This failure prevented the facility from correctly identifying all of the issues in order to develop appropriate plans of care. Findings included: Record review on 02/23/17 of the finalized 5-Day Investigation Report dated 01/20/17 for Client #1 showed, in part, information collected during the facility's investigation in bulleted format below: Physician's Orders dated 11/12/16 were misidentified as &quot;Physician Orders November 2, 2016.&quot; During an interview on 03/15/17 at 9:30 AM, Staff</td>
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<tr>
<td>ID</td>
<td>Prefix Tag</td>
<td>Summary Statement of Deficiencies</td>
<td>Provider's Plan of Correction</td>
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<td>W154</td>
<td>Continued From page 5</td>
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M, Complaint Investigator Manager (CIM), stated that Client #1 was in the hospital on November 2, 2016 and the Physician could not have ordered treatment on that date.

* Nursing Order and Treatment Records dated November 12-December 31, 2016 were used to indicate treatment had been provided.

During an interview on 03/15/17 at 9:30 AM, Staff M, CIM, stated that there was no order for treatment of the wound from November 9-12, 2016.

* December 2016 Nursing Order and Treatment Records showed 5 times that Client #1 had skin monitoring signed as completed and 22 times that were ordered to be monitored were unsigned by nurses.

During an interview on 03/15/17 at 9:30 AM, Staff M, CIM, stated that she believed the nurses had done the treatments on the undocumented days.

* DDA (Developmental Disability Administration) Policy 9.06 (Health Services) showed medical care should be provided as follows: "...nursing care in accordance with healthcare needs...consistent with current standards of health care practice."

During an interview on 03/15/17 at 9:30 AM, Staff M, CIM, stated "Looking at it now, he didn't receive proper care because it wasn't documented as done".

* Interview with Staff K, Registered Nurse
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>D PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
| W 154 | Continued From page 6 | W 154 (RN), showed "Upon review of the nursing notes, he stated that it appears he didn't make an entry after his assessment."  
"Interview with Staff Q, RN, showed "She conducted a head to toe exam on November 9, 2016 and noted a stage 2 breakdown on Client [Client #1 last name] coccyx"  
"December 12, 2016- Staff G, physician, evaluated coccyx wound and noted that it was not dressed properly". |  |  |  |
| W 319 | 483.460(a)(1) PHYSICIAN SERVICES | W 319 The facility must ensure the availability of physician services 24 hours a day. |  |  |  |

This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a physician was available 24 hours a day for one of three Sample Clients (Client #2) when staff were unable to contact a physician to report a concern. This failure put all Clients at risk for not receiving needed medical care and services.

Findings included:

Record review on 03/14/17 of Client #2's file showed Interdisciplinary Progress Notes dated 01/17/17 and timed 2030 (8:30 PM) that identified
**Exhibit 8, Page 8**

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<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
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<td>W 319</td>
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<td>Continued From page 7</td>
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<td>&quot;A) (assessment) alteration in GI, refused med.</td>
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<td>P) (plan) Notify MD&quot;. Additional entry dated</td>
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<td>01/17/17, timed 2215 (10:15 PM) showed &quot;Three</td>
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<td>attempt (sic) to notify MD on call, no answer, will</td>
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<td>inform night shift.&quot;</td>
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<td>During an interview on 03/17/17 at 10:47 AM,</td>
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<td>Staff O. Administrative Assistant, stated that the</td>
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<td>facility did not have a policy related to contacting</td>
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<td>an alternate physicians if the on call physician</td>
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<td>was unavailable.</td>
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<td>W 322</td>
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<td>483.460(a)(3) PHYSICIAN SERVICES</td>
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<td>The facility must provide or obtain preventive and</td>
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<td>general medical care.</td>
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<td>This STANDARD is not met as evidenced by:</td>
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<td>Based on record review and interview the facility</td>
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<td>failed to provide general preventative care for two</td>
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<td>of three Sample Clients (Clients #2 and #3) when</td>
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<td>&quot;rolling maneuvers&quot; were not initiated for Client</td>
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<td>#3, and the physician did not utilize all available/current</td>
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<td>information in order to make an informed decision regarding medical</td>
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<td>care for Clients #2 and #3. This failure possibly</td>
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<td>contributed to the hospitalization/death of Clients.</td>
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<td>Client #2</td>
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<td></td>
<td>Decreased food and fluid intake</td>
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<td>Record review on 03/14/17 of Client #2's file</td>
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<td>showed a Fircrest Admission and Discharge Summary dated</td>
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<td>12/30/16 which identified refusal to eat was &quot;at times&quot; related to constipation and</td>
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<td>&quot;his constipation seems to be associated with</td>
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W 322

Continued From page 8

some degree of anorexia such that when this is improved he does have a better appetite and a history of congestive heart failure and a low sodium level.

Record review on 03/14/17 of Client #2's Health Interdisciplinary Notes dated 01/11/17 showed "...he was shaky .....[Client #2 first name] is not steady on his feet" and "......fine tremor in his head/hands .....MD (physician) notified and orders given for constipation". There was no order for standard laboratory blood work identified in the client's file in relation to current health condition or prior diagnosis of heart failure and electrolyte imbalance.

Record review of Client #2's AC (Attendant Counselor) Nursing Order and Treatment Sheet dated Dec 2016 (Client #2 was admitted 01/05/17) showed documentation of meals eaten:

- 01/11/17-0% breakfast, 100% lunch, 50% dinner, 01/12/17-50% breakfast, no documentation lunch, 25% dinner.
- 01/13/17-0% breakfast, 25% lunch, 0% dinner, 01/14/17-0% breakfast, 25% lunch, 75% dinner, 01/15/17-25% breakfast, 75% lunch, 100% dinner.
- 01/16/17-0% breakfast, 70% lunch, 100% dinner, 01/17/17-100% breakfast, 0% lunch, 0% dinner, 01/18/17-100% breakfast, 100% lunch, 100% dinner.
- 01/19/17 0% breakfast, 100% lunch, 0% dinner and 01/20/17-100% breakfast, 0% lunch, 25% dinner.

Fluid intake was documented by shift:

- 01/11/17 A (AM shift) 8 ounces (oz), P (PM shift)
### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

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<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>W 322</td>
<td></td>
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<td>01/12/17</td>
<td>N (night) no documentation, A 12 oz, P 8 oz.</td>
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<td>01/13/17</td>
<td>N no documentation, A 10 oz, P 0 (zero) oz.</td>
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<td>01/14/17</td>
<td>N no documentation, A 8 oz, P 0 oz.</td>
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<td>01/15/17</td>
<td>N no documentation, A 24 oz, P 8 oz.</td>
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<td>01/16/17</td>
<td>N no documentation, A 16 oz, P 16 oz.</td>
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<td>01/17/17</td>
<td>N no documentation, A 24 oz, P indiscernible.</td>
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<td>01/18/17</td>
<td>N no documentation, A 16 oz, P 10 oz.</td>
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<td>01/19/17</td>
<td>N no documentation, A 48 oz, P 0 oz.</td>
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<td>01/20/17</td>
<td>N no documentation, A 16 oz, P 16 oz.</td>
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During an interview on 03/21/17 at 11:45 AM, Staff G, Physician, stated that he did not order laboratory bloodwork during the admission process or during the change of condition. When questioned if he reviewed the chart or other data when he assessed Client #2 at Klamath house on 01/18/17 he stated he was unsure and he would have ordered laboratory bloodwork if the Client was not eating or drinking.

Weight discrepancy

Review of Client #2’s file showed an Admission and Discharge Summary from Fircrest dated 12/30/16 showed his baseline weight was [redacted] pounds and he had a history of [redacted].

The Admission Assessment at Rainier PAT A, dated 01/06/17, showed a weight of [redacted] pounds.

The Admission Healthcare Assessment dated 01/31/17 (10 days after Client #2’s death) was written in a present tense format. It
<table>
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<th>W 322</th>
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<tr>
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<td>acknowledged a weight of ___ pounds and the statement he had gained &quot;considerable&quot; weight since admission to Rainer. It stated he had no evidence of CHF or symptoms of concern. There were no recommendations for treatment. There was no recommendation to pursue the &quot;considerable&quot; weight gain (___ pounds) or any recommendations to determine if the weight gain could be related to his history of CHF.</td>
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<td>During an interview on 05/16/17 at 10:45 AM, Staff F. Registered Nurse, stated that the scale was thought to be inaccurate and he should have been re-weighed to verify his weight.</td>
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<tr>
<td></td>
<td>Client #3</td>
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<td>&quot;Rolling maneuvers&quot;</td>
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</table>
|       | Record review of Client #3's file on 03/23/17 showed an Annual Healthcare Assessment (AHCA) dated 01/29/16 which stated "It was also critical to initiate rolling maneuvers to reduce ___ cause by his poor motility. This has greatly reduced any residuals and pseudo-___ that previously resulted in hospitalizations and risk for ___." The Individual Habilitation Plan (IHP) dated 01/07/16 showed "he continues to require frequent medical treatment interventions related mostly to management of chronic issues" with an identified need, with Nursing Care Plan (NCP) #8015 listed. NCP #8015, dated 12/03/16, had no interventions listed related to staff rolling Client #3. Physician orders dated 08/23/16 show "Continue to turn side to side Q (every) 2-3 hours to assist with ___". Attendant Counselor (AC) Nursing Order and Treatment Record dated ___.
Continued From page 11

11/01/17 do not include instructions for rolling maneuvers.

During an interview on 05/15/17 at 10:35 AM, Staff U, Qualified Intellectual Disability Professional, stated that health concerns were identified in the conclusion and summary of the 90 day physician review and the AHCA and they were included in the IHP. She stated that she did not remember putting the intervention in the IHP.

During an interview on 05/16/17 at 10:45 AM, Staff F, Registered Nurse (RN), stated that rolling maneuvers should be on the nursing care plan then transcribed on to the AC orders so staff know what to do.

Diarrhea

Record review of Client #3's file on 03/23/17 showed: a Nursing Chronic Problem List which identified [REDACTED], dated 01/25/05 and [REDACTED], dated 08/20/89; an Annual Healthcare Assessment (AHA) dated 01/29/16 which identified a history of [REDACTED] with [REDACTED] and Health Interdisciplinary Notes dated 11/27/16 which identified a summary of Client #3's illness including: decreased [REDACTED], 6 episodes of emesis in 24 hours and a significant change in bowel pattern for the past four days. The nurse documented "MD (physician) suspects viral illness". Document review of the Bristol stool chart located in front of Attendant Counselor (AC) nursing orders at the 201B nurses station contained instructions for AC staff to document the size of the bowel
Continued From page 12

movement (BM) and the consistency using the 1-7 scale on the stool chart. Client #3 was hospitalized on __/16 and later died of surgical complications related to __

During an interview on 03/17/17 at 11:00 AM, Staff G, Physician, stated that he was aware of Client #3’s significant history of __ and did not complete a file review prior to 11/28/16. He also stated that AC staff are to document the consistency of the BM however he would not see the full BM record that contains the consistency of the stool at the clinic or while at the House, only at the 90 day chart review.

During an interview on 05/01/17 at 8:30 AM, Staff S, RN, stated that the facility is working on a policy related to documentation of the consistency of the BM and provided a type written page stating “there is no requirement for nurses to record BM consistency in the medical record”.

A physician must participate in the establishment of each newly admitted client’s initial individual program plan as required by §456.338 of this chapter that specifies plan of care requirements for ICFs.

This STANDARD is not met as evidenced by:

Based on record review and interview the Primary Care Physician (PCP) failed to thoroughly assess one of three Sample Client’s (Client #2) medical status during the admission
Continued From page 13

process. This failure placed Client #2 at risk for bowel impaction/obstruction, bowel perforation, weight loss and dehydration and possibly contributed to his hospitalization.

Findings included:

Record review on 02/21/17 of Client #2’s file showed he was admitted to Rainier School on 02/17/17. A document titled Fircrest RHC (Residential Habilitation Center) Admission and Discharge Summary dated 12/30/16 identified his refusal to eat was "at times" related to constipation and "his constipation seems to be associated with some degree of [redacted] such that when this is improved he does have a better appetite."

Record review of Client #2’s AC (Attendant Counselor) Nursing Order and Treatment Sheet dated Dec, 2016 (Client #2 was admitted 01/05/17) showed documentation of meals eaten:

01/11/17-0% breakfast, 100% lunch, 50 % dinner, 01/12/17-50% breakfast, no documentation lunch, 25 % dinner, 01/13/17-0% breakfast, 25% lunch, 0% dinner, 01/14/17-0% breakfast, 25% lunch, 75% dinner, 01/15/17-25 % breakfast, 75% lunch, 100% dinner, 01/16/17-0% breakfast, 70% lunch, 100% dinner, 01/17/17-100% breakfast, 0% lunch, 0% dinner, 01/18/17-100% breakfast, 100% lunch, 100% dinner, 01/19/17 0% breakfast, 100% lunch, 0% dinner 01/20/17-100% breakfast, 0% lunch, 25% dinner.

Fluid intake was documented by shift:
### W 329

Continued From page 14

01/11/17 A (AM shift) 8 ounces (oz), P (PM shift) 8 oz.
01/12/17- N (night) no documentation, A 12 oz, P 8 oz.
01/13/17- N no documentation, A 10 oz, P 0 (zero) oz,
01/14/17-N no documentation, A 8 oz, P 0 oz,
01/15/17-N no documentation, A 24 oz, P 8 oz,
01/16/17 N no documentation, A 16 oz, P 16 oz,
01/17/17-N no documentation, A 24 oz, P indiscernible,
01/18/17-N no documentation, A 16 oz, P 10 oz,
01/19/17 N no documentation, A 48 oz, P 0 oz,
01/20/17 N no documentation, a 16 oz, P 16 oz.

Record review of Client #2's Medication Administration Record (MAR), undated, showed no bowel movement (BM) from 01/06/17-01/10/17 with two small BM's recorded on 01/11/17. Client #2 then went another three days without a bowel movement with a medium BM recorded on 01/15/17 and two days later a medium was recorded on 01/18/17.

Documentation was missing on 01/19/17-01/21/17 (the date Client #2 was hospitalized).

During an interview on 03/21/17 at 11:45 AM, Staff G, Physician, stated that he had seen the discharge summary prior to admission however he was not aware of the refusal to eat in relation to constipation and he did not identify interventions for medical needs regarding constipation in the initial physical exam.

483.460(c) NURSING SERVICES

The facility must provide clients with nursing services in accordance with their needs.

### W 331

The facility must provide clients with nursing services in accordance with their needs.
This STANDARD is not met as evidenced by:

Based on record review and interviews the facility failed to provide nursing services to meet the needs of three of three Sample Clients (Client #1, #2, and #3) when medical concerns were not identified, addressed or followed up with the physician, treatments were not completed as ordered by the physician and Clients were not monitored for change in condition. This failure resulted in Clients not receiving needed care and nursing services, and possibly contributed to hospitalization of, and the deaths of Clients #2 and #3.

Findings included:

Client #1

Record review on 01/26/17 of Client #1’s file revealed;

The Treatment Administration Record (TAR) for November 2016 revealed there was no treatment ordered/identified for a skin wound from 11/8/16-11/12/16 and there were 13 days the treatment for Client #1’s wound was ordered to be changed daily; however it was only signed as completed four times from 11/12/16-11/30/16.

The TAR for December 2016 revealed “check skin on buttock BID (twice a day) and report to RN/MD if not healing”. Staff signed the TAR as completed 21 times out of 62 opportunities to monitor as ordered. An additional order to check BID was missing documentation 11 times from 12/10-12/31/16.

The Nursing Problem/Diagnosis form identified
W 331 Continued From page 16

Risk for Impaired skin integrity and no additional interventions were identified in relation to actual skin impairment noted on 11/16 or 12/16 when Client #1 was readmitted to the facility from the hospital.

During an interview on 01/25/17 at 11:40 AM, Staff A Registered Nurse (RN), stated that the Primary Care Nurse (PCN) for each house was responsible for monitoring documentation for completion and accuracy and reporting to Staff B, RN, for follow up. She also verified the plan of care was not updated as there is not a separate plan for "open areas" and the care plans "are used for everybody".

Interview on 01/26/17 at 9:30 AM with Staff B, RN, verified the facility does not have a policy or procedure to monitor skin to identify if a wound is healing and each house has their own Primary Care Nurse (PCN) responsible for care of Clients, including creation of the plan of care and wound management.

Client #1

Bowel Movements

Record review on 03/17/17 of Client #1's file showed a Medication Administration Record (MAR) for October 2016 indicated Client #1 had a physician order to receive a rectal suppository for no bowel movement (BM) in four days. There was no documentation on the MAR on 10/20/16 that a suppository was given. The Client was hospitalized on 11/16 and had surgery for a Review of the November 2016 MAR indicated he should have received a rectal suppository on 11/14/16.
### W 331

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11/19/16, and 11/23/16, as there was only one BM documented in 14 days post hospitalization for a [redacted]. There was no documentation on the MAR that a suppository was given for those dates.

Record review on 04/10/17 of Client #1's file showed the MAR for January 2017 indicated Client #1 should have had a rectal suppository on 01/21/17 and 01/26/17 for no BM in four days, as ordered by the physician. There was no documentation on the MAR that a suppository was given.

During an interview on 05/16/17 at 10:20 AM, Staff A, RN, stated that the nurses document the BM from the Attendant Counselor (AC) worksheets onto the MAR and the nurse is responsible for initiating the ordered treatment and the Client did not receive the medication as ordered.

Client #2

Alert charting

Record review on 02/21/17 of Client #2's file showed Health Interdisciplinary Notes dated 01/05/17 at 12:10 PM with admission information, 01/06/17 at 1930 (7:30 PM) refusal of medication, and 01/09/17 at 0915 (9:15 AM) Direct Care Staff documentation. Review of Klamath House Alert Charting Schedule showed a beginning date of 12/12/16 and end date of 01/13/17 with Client #2 listed once on 01/13/17 for monitoring of "Oral mucous membrane thrush".

During an interview on 02/21/17 at 12:30 PM, Staff B, Registered Nurse (RN), stated that new
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admissions should have a minimum of three days and evenings of nursing charting when admitted to the facility. At 2:20 PM she stated that the facility does not have a policy to identify when Clients would be placed on alert status or how long to monitor for different concerns.

During an interview on 02/23/17 at 11:45 AM, Staff F, RN, stated that Client #2 was not on alert status upon admission nor during changes in his condition.

Dehydration

Record review on 02/21/17 of Client #2's file showed an order for Lithium 300mg (milligrams) twice a day. Health Interdisciplinary Progress Notes dated 01/11/17 timed 0920 (9:20 AM) “Spoke with [Staff G, Physician] about client decrease food and fluids ...” The next entry at 1600 (4:00 PM) identified "A (assessment) dehydration P) (plan) Staff G, Physician, notified and orders given for dx (diagnosis) Will monitor”. There was no physical assessment of hydration status documented for Client #2. The Nursing Order and Treatment Record for Attendant Counselor (AC) staff indicated food and fluid Intake monitoring was initiated on 01/11/17. The next entry is dated 01/13/17 and does not address hydration status of Client #2 nor evaluation of his food/fluid intake as documented on the Treatment Record. Per facility documentation, Client #2 accepted only 16 ounces (oz) of fluid on 01/11/17 and 20 oz on 01/12/17. Review of progress notes from 01/13/17 to 01/21/17 (date of hospitalization) showed no physical assessment of Client #2’s hydration status nor analysis of intake which continued to be significantly less than
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Details</th>
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<tbody>
<tr>
<td>02/23/17</td>
<td>During an interview on 02/23/17 at 11:00 AM, Staff F, RN, stated that nurses should have looked at his intake daily however the information was in the Attendant Counselor flowsheets so they didn't see it daily. She also stated that the doctors knew how much Client #2 was drinking and that he was not on alert status related to monitoring his intake.</td>
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<tr>
<td>03/23/17</td>
<td>Record review on 03/23/17 of Client #3's file showed: Health Interdisciplinary Progress Note dated 11/26/16 (untimed) which identified &quot;Abd (abdomen) round &amp; distended&quot;. There was no documentation of physician notification of that finding identified in Client #3's record. Physician Order dated 11/26/16 and timed 1415 (2:15 PM) had instructions to call the physician if emesis continued. Health Interdisciplinary Progress Notes dated 11/26/16 at 2145 (9:45 PM) stated &quot;One large and one small emesis since began Pedialyte&quot;. No notification of continued emesis to physician was identified in the notes dated 11/26/16.</td>
</tr>
<tr>
<td>05/01/17</td>
<td>During an interview on 05/01/17 at 8:30 AM Staff S, RN, stated that the physician should have been notified of Client #3's distended abdomen</td>
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**Note:** The text on the page contains a redacted section which seems to be a type of measurement or a product name, but the specific details are not clear from the image.
W 331  Continued From page 20
and continued emesis.

W 338  483.460(c)(3)(v) NURSING SERVICES

Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to identify when a wound/condition deteriorated and notify the physician accordingly for one of one Sample Clients (Client #1). This failure prevented changing the plan of care/treatment to avoid further decline of condition and/or improve physical condition.

Findings included:

Record review on 01/25/17 revealed a Health Interdisciplinary Progress Note dated 12/17/16 stated "2.4 cm widening mased (sic) skin, width and length equally 2 cm, wound opening measure .4 cm wide" and "seemingly widening from what I have notices (sic) previously". There was no indication the Primary Care Nurse (PCN) or the physician was notified of the change in the wound. Progress note date 12/20/16 stated "Dsg (dressing) not staying on. Changed again same size-maybe deeper". There is no indication the Primary Care Nurse or Physician was notified of the documented change in the wound.

During an interview on 05/01/17 at 8:30 AM, Staff S. Registered Nurse (RN), stated that the physician should be notified of any change in
| W 338 | Continued From page 21 condition. |
| W 339 | 483.460(c)(4) NURSING SERVICES |

Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to implement interventions consistent with physician orders and the standard of nursing practice when an order was not initiated timely, the wrong treatment was used for a wound and a plan was not developed in relation to medication refusal for three of three Sample Client (Client #1, #2 and #3). This failure prevented Clients' medical needs from being met and placed Clients at an unnecessary risk for harm.

Findings included:

Client #1

Record review on 01/25/17 of Client #1’s file showed a Health Interdisciplinary Progress Note dated 11/09/16 which identified skin breakdown and included the statement "new orders written". No order was found in the chart and no treatment was identified on the Treatment Administration Record (TAR) for that date.

In an email communication on 02/26/17 to the surveyor, Staff A, Registered Nurse (RN), stated that she could not verify whether or not treatment had been ordered for Client #1’s [redacted] wound from 11/09/16-11/12/16.
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<thead>
<tr>
<th>ID</th>
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<th>Date</th>
<th>Completion Date</th>
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<td>W 339</td>
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Record review on 01/25/17 of Client #1's file showed a Physician note in the Health Interdisciplinary Progress Notes dated 12/12/16 which stated "not dressed properly".

During an interview on 01/26/17 at 9:30 AM, Staff B, Registered Nurse (RN), stated that staff have not been trained in use of the facility's treatment supplies.

Client #2

Record review on 03/14/17 of Client #2's file showed a Medication Administration Record (MAR) dated January 2017. Client #2 had one small bowel movement in the 8 days he was at the facility and was ordered to be given on 01/13/17 at 1600 (4:00 PM). The medication was refused by Client #2 as evidenced by a capital R which was circled on the MAR. There was no documentation on the back of the MAR for 01/13/17. Review of the facility Medication Administration Policy showed "If medication is refused a circle is entered in appropriate time/date block on the MAR. The nurse must document each occurrence on the back of the MAR.....Nurse must notify the RN of the incident.....who will notify the PCP/MD by phone for medications of significant impact ..... ."

Review of the Health Interdisciplinary Notes for 01/13/17 showed no entries after 1400 (2 PM).

During an interview on 03/17/17 at 8:55 AM, Staff F, RN, stated the nurse should have notified the RN and documented according to the policy.
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During an interview on 03/21/17 at 11:45, Staff G, Physician, stated that he was not notified of the medication refusal.

Lack of bowel protocol

Record review on 02/21/17 of Client #2’s file showed a Medication Administration Record (MAR), (undated however Client #2’s name was handwritten on it) that indicated he had not had a bowel movement (BM) in the first five days since admission on [redacted] 17. No interventions were identified on the MAR to treat lack of a bowel movement. After having two small BM’s on 01/11/17 Client #2 did not have an additional BM until 01/15/17. Record review of a report of an x-ray obtained 01/20/17 showed moderate stool in colon compatible with constipation.

During an interview on 05/01/17 at 8:30 AM, Staff S, RN, stated that the facility did not have a policy for monitoring BM’s or interventions for Clients that did not have an individual protocol for treating constipation.

Client #3

Record review on 03/23/17 Client #3’s file showed:

- an Annual Healthcare Assessment dated 01/29/16 which stated “It was also critical to initiate rolling maneuvers to reduce [redacted] caused by his poor motility. This has greatly reduced any residuals and pseudo- [redacted] that previously resulted in hospitalizations and risk for bowel obstruction.” And “We will continue his very important rolling maneuvers …...”
- an AC (Attendant Counselor) Nursing Order...
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<td>Treatment Record dated November 1, 2016 with no order for rolling maneuvers listed.</td>
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<td>-a telephone Physician Order dated 08/22/16 which stated &quot;Bowel PT (Physical Therapy)- roll side to side to move gas through&quot;. No order to discontinue it was found in the record.</td>
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<td>During an interview on 05/05/17 at 12:20 PM, Staff T. Developmental Disability Administrator 2, stated that physician orders that need to go into the Individual Habilitation Plan (IHP) would go through nursing to be placed on the AC orders.</td>
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<tr>
<th>W 460</th>
<th>FOOD AND NUTRITION SERVICES</th>
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<td>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</td>
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This STANDARD is not met as evidenced by:

Based on record review and interview the facility failed to provide a diet as medically prescribed for one of three Sample Clients (Client #2). This failure put the Client at risk for adverse food reactions.

Findings included:

Record review on 02/21/17 of Client #2's file showed a Physician's Dietary Order dated 01/06/17 which indicated a diet order as "Pureed, Mild Free (no Milk or Milk Products). A facility Food and Nutrition Client Dietary List obtained at Klamath House showed "[Client #2 first/last name] 1500 PR, No milk or milk products." Review of the Health Interdisciplinary Progress from 01/11/17-01/20/17 showed five dates that
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staff gave pudding, yogurt and Ensure pudding which all contain milk/milk products.

During an interview on 02/21/17 at 10:30 AM Direct Care Staff stated that Client #2 could not have milk, however he could have pudding.

During an interview on 03/21/17 at 11:45 AM Staff G, Physician, stated that the diet was to be no milk/milk products, as written.