No More Excuses
Shining a spotlight on abuse and neglect of people with developmental disabilities living at Rainier

January 2018
A letter from the Executive Director

Dear Reader,

Rainier, a Residential Habilitation Center, is a dark place. State surveyors have found that:

• People are left for hours on end with nothing to do and no human interaction;
• People are treated inhumanely as staff bark orders at them when they do not do as staff want;
• People do not have safe food to eat that meets their swallowing needs, and staff do not know how to properly perform the Heimlich maneuver, putting residents at risk of dying every time they eat each day; and
• People died from what is believed to be improper medical care.

All of this happened in just the last year.

These are not merely opinions or unsubstantiated assertions. All of these serious problems were observed and recorded by state officials investigating the conditions and care at Rainier. The persistent issues resulted in the federal government deciding in late December to decertify one of Rainier’s programs for failing to meet federal legal requirements to provide minimally adequate care. Notably, the serious problems occurred while Rainier staff knew state investigators were on site and watching them. I am deeply troubled by not only these examples of seriously poor care, but also the question of what happens on the days no one is watching.
Our state is paying for and directly operating Rainier. The conditions at Rainier are unacceptable and cannot continue. Every person should be safe in their own home, no matter who they are or where they live. Rainier residents are not safe, and it is despicable that taxpayers are the owners and operators of such a facility. The residents of Rainier must be kept safe and given the services they need and are legally entitled to receive. This is just the bare minimum of the law, and it is simply human decency.

The neglect must end now. No more excuses.

I know reading this report is disturbing. I hope, however, that the discomfort it causes you as a reader motivates you to act to help those who have to live in these conditions at Rainier every day. If it does, please email facilities@dr-wa.org to let us know what you are doing to help in this fight and to 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

Washington State pays for and operates a place with a history of neglect and abuse of people with developmental disabilities called Rainier.\(^1\) Currently, approximately 310 people live in this institution and have sacrificed a life in the community to receive safe and appropriate care.\(^2\) Year after year, however, residents of Rainier live in danger. Death, verbal abuse, and careless medical attention are just some of the serious harms people face. All the while, Rainier fails time after time to provide the treatment it exists to provide.

The state is responsible for surveying Rainier to determine whether or not the institution meets federal standards for operation.\(^3\) Under these standards, at least two basic conditions must be met: people must be safe and people must receive appropriate treatment.\(^4\) Rainier is failing on both fronts, and it is not an isolated failure. In 2017 alone, the state’s own surveyors have found that people living in Rainier are in constant danger of choking to death, treated with disrespect, and left for hours and hours alone with nothing to do. Simultaneously, people at Rainier are being
denied the skills training that Rainier exists to provide and receives federal and state money to provide. These failures are so pervasive that the federal government recently decided that it would decertify a portion of the institution and no longer pay for its services.  

_No More Excuses_ sheds light on the pattern of unsafe conditions and lack of treatment occurring at Rainier, as identified in the state’s own surveys. While most of this information is publically available, it is apparent that the problems continue and meaningful change is needed. 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 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.

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.
Purpose

The purpose of this report is to describe the continuing harm that people with developmental disabilities experience at Rainier, one of Washington State’s four state-run Residential Habilitation Centers (RHCs). Last year, Disability Rights Washington released a report entitled *No Excuses*, shedding light on the pattern of unsafe conditions and lack of treatment in Washington’s four RHCs in calendar year 2016, as identified by the state’s own surveys. In *No Excuses*, Disability Rights Washington called state leadership to action so that people with developmental disabilities would no longer face dangerous conditions and endure neglect in these institutions. Unfortunately, serious harm continues.

This year, Disability Rights Washington shines a spotlight on Rainier and the harm its residents faced in 2017. As in 2016, Rainier has continued to endanger the lives of people with developmental disabilities while failing to provide the necessary treatment for which their residents have given up a place in the community to receive. As explained in *No Excuses*, being safe in your own home is the most basic expectation any human being has, and people who live at Rainier have that same basic expectation. The failure to keep these individuals safe is more egregious in light of Rainier’s continuing failure to provide the active treatment it is supposedly designed to deliver. Rainier exists for the sole purpose to support individuals in achieving their highest level of abilities through a
comprehensive educational program known as active treatment. 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. Each person who lives at Rainier is supposed to be protected by federal law that gives them the right to individualized active treatment and prevents the institution from simply ignoring and warehousing them.

**Oversight authority**

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) is the state agency that conducts required inspections and surveys on behalf of CMS to license and certify long-term care facilities, including Rainier. RCS conducts surveys of the RHCs at least every 15 months.

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 for new admissions.
Scope and methodology

The problems contained in this report are pulled directly from the surveys and findings of RCS, the state agency responsible for surveying Rainier, from the 2017 calendar year. Throughout this report are references to the findings contained within Disability Rights Washington’s earlier report *No Excuses* that exposes issues found in the state’s own surveys from 2016. This report also 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 at Rainier are still being harmed

Personal safety is a minimal and basic expectation of residents of Rainier. 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. In 2016, the state’s own RCS surveys revealed that in just one year, people living at Rainier suffered sexual assault, choking, malnourishment and a lack of medical care. News outlets quoted State leadership who responded immediately to *No Excuses* by blaming “a few bad actors” and suggested that the problems were being fixed. In actuality, Rainier residents remain at serious risk of choking deaths and dying from lack of medical care, all the while experiencing abusive treatment from staff.
People remain at risk of choking even after choking deaths in 2015 and 2016

It is not unusual 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 avoid choking. Moreover, the Washington State Department of Social and Health Services has long known that aspiration is one of the leading causes of death among individuals with developmental disabilities. Still, people living at Rainier remain at risk for choking, even after repeated citations and deaths for failing to follow dietary plans.

*No Excuses* recounts the stories of two men who choked to death while under the care of Rainier almost exactly a year apart. Both men had dietary restrictions in their individualized plans to help keep them safe. One of the men choked to death on a peanut butter and jelly sandwich in August of 2015 at a summer picnic. The other man choked to death on a hotdog during Rainier’s annual summer event in 2016. In both situations, Rainier failed to follow necessary plans, and this failure led to their deaths. Shockingly, in 2017, Rainier staff continued to fail to follow prescribed dietary plans, making it only a matter of time before another person chokes to death.

“Still, people living at Rainier remain at risk for choking, even after repeated citations and deaths for failing to follow dietary plans.”
In January 2017, while RCS observed, Rainier staff cued one man to dish up his lunch of chopped fish and carrots for himself. Staff also cued him to dish himself up whole french fries. RCS reviewed the man’s individualized plan dated three months prior and it revealed that the man requires a chopped diet due to his risk of choking while eating. RCS verified during an interview with staff that the french fries should have been chopped to prevent the risk of choking.17

Another man’s individualized plan requires any meat to be chopped before he eats it to prevent him from choking. RCS observed the man in August of 2017 eating sliced meat cut into two inch pieces. The next day, RCS observed the same man being served an entire hamburger, both the patty and bun, was cut into one-inch pieces. Staff confirmed during an interview that the meat should have been “altered” and the hamburger patty should have been chopped before it was placed on the whole bun,
rather than just cutting the entire hamburger into pieces including the bun. In both situations, Rainier staff put the man at risk of choking to death on his food.\textsuperscript{18} During the same visit in August, RCS observed a different man eating spiral noodles that were approximately two inches long. Review of his individualized plan revealed that the man required his food to be ground before consumption to prevent choking. During an interview that day, Rainier staff told RCS that the noodles the man ate did not need to be ground because they were “mushy.” However, during another interview three days later, the same staff person admitted that the noodles should have been ground.\textsuperscript{19}

Rainier still did not have the risk of choking resolved in October of 2017 when RCS determined that Rainier’s non-compliance with federal laws resulted in the immediate jeopardy of one man after four incidents of eating food outside of his prescribed diet texture in five months.\textsuperscript{20} Rainier’s own investigation revealed that because the man is at high risk for
aspiration, he requires his food to be pureed into a soft, smooth paste consistency, and staff is to supervise him within line of sight at all times. In May, the man ate an item prohibited by his dietary restriction while he was unsupervised, in August he obtained something prohibited by his dietary restriction while he was unsupervised, and again in August he was found with crumpled bread in front of him. When RCS entered his Rainier home to investigate two reported incidents involving the man eating foods outside of his prescribed diet that put him at risk of choking, the man was observed by the RCS surveyor standing in the kitchen holding three pieces of half eaten white bread. He was eating the remaining pieces of bread. No staff were present at the time. When a staff person entered the kitchen, she stated “you aren’t supposed to have that” and attempted to remove the bread from his mouth with her bare hands. RCS found that Rainier failed to ensure there were sufficient staff to provide the needed supervision for this man, and to prevent repeated incidents of him eating foods outside of his prescribed diet texture. By not following the man’s individualized plan, staff put him at risk for aspiration pneumonia, choking, and death.
Moreover, staff have lacked the ability to identify when and how to administer the Heimlich maneuver even after countless near choking incidents and two deaths during the last few years. In one such case, a man began to cough hard in front of Rainier staff after eating a brownie. After the man coughed off and on for about four minutes, a staff put the man at risk of serious injury when he improperly performed the Heimlich maneuver, and then ordered the man to walk around the house to “keep his airway open.” After the event, the man repeatedly stated that he had a cold. Based on interviews after the incident, RCS learned that the staff made multiple errors. First, the staff should not have administered the Heimlich given that the man was still breathing. Second, the staff improperly administered the Heimlich while the man was still seated. Finally, the staff should not have ordered the man to walk around afterwards. On top of the numerous, potentially life threatening mistakes, the staff person also admitted to RCS that his CPR card was expired at the time.\(^\text{23}\)

Many of these incidents happened while RCS was physically present and observing meal times or other times residents were eating. There is no way to know how often the men and women living at Rainier are put at risk of choking and incompetent first aid when no one is watching and staff are not on their best behavior.

**People are dying because of a lack of medical care**

Rainier is federally required to provide or obtain through an outside provider both preventative and general medical care for its residents.\(^\text{24}\) Federal law also requires Rainier to ensure the availability of physician services 24-hours a day. This includes, but is not limited to, retaining a physician who develops, in coordination with licensed nursing personnel,
a medical care plan of treatment for residents who require 24-hour licensed nursing care.\textsuperscript{25}

Rainier failed, however, to provide general preventative care for two residents, and Rainier’s physician did not utilize all the available, current information about these individuals to make an informed decision regarding their medical care. The information in the state’s surveys is limited, but RCS makes the conclusion that Rainier’s failure possibly contributed to the hospitalization and death of two residents.\textsuperscript{26} The survey indicates that one resident was hospitalized because Rainier staff failed to document and treat his medical condition.\textsuperscript{27} After hospitalization because of Rainier’s failure to treat him appropriately, the man died. Rainier even dated an assessment in the present tense 10 days after his death.\textsuperscript{28} A second resident was also hospitalized and later died of surgical complications because again, Rainier failed to treat the resident’s grave medical condition.\textsuperscript{29}
Dangerous situations still exist, even after two deaths related to medical care. Rainier residents are at constant risk of serious harm because staff are unable to contact a physician to report a concern, even though Rainier is required to provide 24-hour medical care to residents. An RCS record review revealed that a Rainier resident’s medical notes from January of 2017 documented that one staff tried three times to speak with the physician on call, but the physician never answered. RCS interviewed an administrative assistant who admitted that despite the requirement that residents have 24-hour access to a doctor, “the facility did not have a policy related to contacting an [sic] alternate physicians if the on call physician was unavailable.” Not only is this a violation of the laws that provide for Rainier to receive federal funding, but it also makes Rainier a dangerous place for people who rely on the medical care Rainier is supposed to provide.

People are not treated with dignity or respect

As one man sat on the couch in the living room of his Rainier cottage in January of 2017, RCS observed that staff frequently ordered the man around in a loud and commanding tone. He was sternly told to “sit up straight” and to “wipe [his] drool.” Later, three staff frequently gave him commands as he ate his lunch to “sit up straight,” “wipe your mouth,” “put your spoon down,” “what’s in your mouth,” “and swallow before you talk.” This type of aggressive criticizing continued to occur the entire time he ate his meal until he was finished, right under the eyes of a RCS surveyor.”
RCS surveyor.\textsuperscript{32}

At the same house, another man tried to stand up from the dining table and walk away. RCS observed a staff person pull on his jacket and demand “where are you going?” Then, the staff pushed a serving tray into the man’s stomach stating, “[t]ake this to the kitchen.” During an interview two days later, three different staff members verified that they were aware of Rainier staff using forceful language when caring for residents. Rainier staff also disclosed they have witnessed staff being brash and overbearing with residents.\textsuperscript{33}

**Summary**

Men and women who live at Rainier are at risk of being hurt every day. Two deaths from choking within just one year was not enough to prompt necessary changes to reduce the risk of choking, as people eat foods that are specifically identified as dangerous. Although Rainier is legally required to provide medical care to residents, people have been hospitalized and died from what is believed to be improper medical care. It is just a matter of time before another person dies a preventable death from choking on food that should have been modified or is harmed or dies from the failure to receive adequate first aid or medical care. Other people are living at the mercy of aggressive caregivers who did not treat people with dignity right in front of state surveyors.
Rainier is still failing to provide necessary disability related services to people with developmental disabilities

Besides needing staff to keep them safe, the people who live at Rainier must receive services to help them become more independent. In order for residents of Rainier to work towards living independently, Rainier staff must 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 build upon those skills. The daily implementation of the plans must be tracked and reviewed to determine whether the plans are actually working and the resident is gaining needed skills. The failure to deliver these services is comparable to being a professor at a college, but just showing up to the classroom and never providing instruction. In effect, the individuals are merely warehoused while the institution holding them receives federal and state money under the guise of providing active treatment to residents.

Three signs posted on a door at Rainier. One sign includes red handwritten lettering that reads, “About Active Treatment!”
People spend their days sitting around without activities

People with developmental disabilities live at Rainier, rather than in the community, to obtain the skills they need to ultimately move out and live more independently.\textsuperscript{35} Rainier is funded to do this and designed for this sole purpose.\textsuperscript{36} No Excuses exposed repeated violations of the federal laws that require Rainier to provide active treatment evidenced by RCS surveys that showed that residents sit alone day after day without staff providing proper training.\textsuperscript{37}

In October of 2016, RCS imposed a denial of payment for new admissions to a portion of Rainier for 11 months based on persistent non-compliance with active treatment services. Still, Rainier repeatedly continued to fail to comply with these federal laws in 2017.\textsuperscript{38} For example, RCS observed a man as he sat in his wheelchair in the hallway, living room or on the patio all the
while doing nothing for almost two hours, except for a short excursion to check the mail with staff. Later that day, RCS observed him while he sat again in his wheelchair in the living room doing nothing for over an hour.\textsuperscript{39} All of this occurred during an RCS visit to Rainier in May of 2017 after Rainier already had been repeatedly cited for failures to provide active treatment including leaving people sitting alone for long periods of time without activities.\textsuperscript{40} Notably, during the RCS visit in May, surveyors observed seven other residents who also were left alone, unengaged in learning activities for long periods of time.\textsuperscript{41} Even after multiple RCS visits and findings of violations of federal laws, people continue to be neglected at Rainier.

\textit{Resident sits alone in a common room in a cottage at Rainier.}

Violations continued during an RCS visit in August of 2017. State surveyors found that Rainer failed to ensure that seven random sample residents were actively engaged in legally required treatment and training. Instead,
residents sat around with nothing to do.\textsuperscript{42} One man was observed by RCS for over two hours, and during the two hours, the man did not receive any active treatment. During this time, he walked alone in the middle of the street on his way to work when Rainier staff could have helped him walk on the sidewalk to avoid moving vehicles. The man appeared to nap during his work shift, while Rainier staff could have taught him new skills. When he was assigned work, it consisted of tedious tasks which he already knew how to complete. He was not provided with any training during the entirety of his shift. No staff members appeared to engage with him in order to help him learn new skills. Review of this man’s file showed that Rainier staff were supposed to assist him in reaching numerous training objectives. However, Rainier repeatedly failed to provide him with active treatment. Numerous educational opportunities were ignored to help the man become more independent and live in a less restrictive setting.\textsuperscript{43}
Staff do not follow individual plans related to skill building

Rainier is required to develop plans for each person to gain independence. However, the mere existence of these plans alone is insufficient; Rainier staff must follow the plan, document the individual’s progress, and modify the plan as necessary.44

One woman living at Rainier needed to use a picture board to communicate her wants and needs to staff. A picture board would have allowed the woman to point to items she wanted such as water or snacks, or identify care that she needed such as using the restroom. Her plan from June of 2017 showed that to assist her in communicating, Rainier staff would trial a simple picture system. Three days of RCS observations in August of 2017, however, revealed that the woman did not use a picture communication system at all, and staff verified that they had not implemented a picture communication system for her.45 Notably, the survey notes that this was a repeat citation from July of 2016. Rainier initially corrected the violation, but failed to maintain compliance and received the same citation in August of 2017.46

Summary

These pervasive failures to provide active treatment prevents these individuals from learning and retaining skills. Rainier must create, implement and track plans to ensure people are obtaining new independent living skills. Rainier has been cited repeatedly for failing to provide active treatment. This pattern of neglect both hurts residents in the moment and limits their futures by preventing the opportunity to move from Rainier to a less restrictive living setting as soon as possible.47
People with developmental disabilities reside in Rainier 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. Instead, residents sit alone day after day without staff providing proper training. Compounding the harm of being denied opportunities to gain new skills, people are left hour after hour without staff engagement or meaningful activities.

**Conclusion**

The current conditions at Rainier cannot be viewed in a vacuum. There is a clear pattern of significant harm occurring at Rainier, and the abuse and neglect cannot continue.

**2015**

Rainier received a denial of payment for new admissions for a portion of Rainier when RCS determined it was out of compliance with federal law regarding minimum standards, including failures to protect clients and provide active treatment. Rainier’s failure to follow one man’s necessary, documented dietary needs led him to choke to death. Instead of ensuring the safety of residents with dietary restrictions, another man choked to death one year later. The risk is preventable, but today, countless men and women are at risk of choking.

**2016**

RCS imposed a denial of payment for all new admissions to a portion of Rainier for 11 months based on Rainier’s non-compliance of federal
conditions for participation.\textsuperscript{50} Surveys from 2016 reveal residents throughout Rainier faced a long list of dangerous conditions. A Rainier resident choked to death, at least one Rainier resident was sexually assaulted by a Rainier staff, and a Rainier resident nearly drowned. All the while, Rainier staff repeatedly failed to provide the active treatment the institution exists to provide, and men and women sat day after day with nothing to do.\textsuperscript{51}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{protest_signs.png}
\caption{A group of advocates hold signs in protest of the conditions at Rainier.}
\end{figure}

\textbf{2017:}

Approximately 310 adults with developmental disabilities currently live at Rainier, and every single resident lives at risk of abuse, neglect and even death. In December, after a long record of failures to provide active treatment and protect its residents, the federal government decertified a portion of Rainier due to pervasive and uncorrected deficiencies. People are treated with disrespect and without dignity. After repeated citations,
Rainier continues to fail to provide active treatment. In the 2017 calendar year alone, RCS sent two letters finding immediate jeopardy to Rainier’s residents. Finally, near the end of 2017, RCS consulted with Centers for Medicare & Medicaid Services and because of ongoing noncompliance, decertified a portion of Rainier.

This report only highlights some of the problems that deeply affect the everyday lives and safety of people living in Rainier. Disability Rights Washington’s history is rooted in the need to prevent and combat abuse and neglect in institutions, following the harrowing exposé in the 1970s of the Willowbrook State School, an institution in New York. Congress created organizations like Disability Rights Washington to serve as “protection and advocacy systems” to ensure watchdogs existed in conditions of facilities housing the nation’s citizens with disabilities. As evidenced in No Excuses and in this report, however, grave conditions persist at Rainier and excuses continue to be made for why residents are regularly denied a safe, dignified, supportive home. Over 40 years later, people with developmental disabilities should not continue to face warehousing in institutions where they do not receive necessary treatment to live independently in unsafe and abusive conditions.
The ongoing harm to residents and the federal government’s decision to decertify confirms that much more needs to be done to keep the people living at Rainier safe and to provide them with the treatment they need. This will take strong and effective leadership from the state to take responsibility for the shameful pattern of abuse and neglect that has occurred over the last several years. A change needs to happen now. No excuses.

About the author

Reisha Abolofia is an 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

1 Rainier School [hereinafter Rainier] is a Residential Habilitation Center. 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. The Developmental Disabilities Administration directly runs Washington’s four RHCs, including Rainier, which is licensed as an intermediate care facility. People living at Rainier are legally entitled to receive 24-hour supervision, medical services, and active treatment. See Residential Services, Developmental Disabilities Admin., Washington State Dep’t of Soc. and Health Serv., https://www.dshs.wa.gov/dda/consumers-and-families/residential-services (last visited Jan. 3, 2018).


3 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 state performs for CMS under the agreements in Section 1864 of the Social Security Act (the Act) are referred to collectively as the certification process.”).

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

5 Letter from Candace Goehring, Director, RCS, to Administrator/Superintendent, Rainier School PAT E, (Sep. 8, 2017), attached as Exhibit 1; letter from Steven Chickering, Associate Regional Administrator, Western Division of Survey and Certification, to Administrator, Rainier School Pat E, (Dec. 19, 2017), attached as Exhibit 2.


7 42 C.F.R. § 483.440(a).

8 Supra note 3.

9 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 Jan. 3, 2018) (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.”).


13 DSHS archives each RCS survey for the public to view on its website. Both publicly and privately 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/adssaapps/lookup/ICFIDLookup.aspx. By clicking “View Reports” next to one of the three Rainier PATs, a person can access the relevant RCS surveys. Disability Rights Washington compiled, reviewed and synthesized all of the RCS’s findings from the 2017 surveys available for Rainier PAT A, C and E.


17 RCS Statement of Deficiencies (hereinafter “SOD”) and Plan of Correction (hereinafter “POC”) for survey dated 1/6/2017, Rainier PAT C (finding violation W249 citing 42 C.F.R. § 483.440(d)(1)), attached as Exhibit 3, pages 19, 21. (redacted survey reads: “record review on 1/3/17 of Client #6’s IHP dated 10/27/16 revealed that he was prescribed a chopped, [redacted] diet due to [redacted], risk of choking and [redacted].”).


19 RCS SOD and POC for survey dated 8/29/2017, Rainier PAT E (finding violation W249 citing 42 C.F.R. § 483.440(d)(1)), attached as Exhibit 4, pages 50-52. The survey references Standard
Operating Procedure 4.07 Appendix A, Diet Textures, dated 04/2015, which states that a ground diet consists of food pieces no larger than $\frac{1}{4}$ inch in diameter.

20 Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, RCS, to Jeff Flesner, Superintendent, Rainier School PAT A (Oct. 6, 2017), attached as Exhibit 5.


22 RCS SOD and POC for survey dated 10/4/2017, Rainier PAT A (finding violation W104 citing 42 C.F.R. § 483.410(d)(1), W186 citing 42 C.F.R. § 483.430(d)(1-2)), attached as Exhibit 6, pages 1-6. Of note, in responding, the staff also violated this man's positive behavior support plan which instructed staff to “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 swallows.”

23 RCS SOD and POC for survey dated 3/21/2017, Rainier PAT C (finding violation W189 citing 42 C.F.R. § 483.430(e)(1)), attached as Exhibit 7, pages 1-2.

24 See 42 C.F.R. § 483.460(a)(3).

25 See 42 C.F.R. § 483.460(a)(1)-(2).


27 RCS SOD and POC for survey dated 6/29/2017, Rainier PAT A (finding violation W322 citing 42 C.F.R. § 483.460(a)(3); finding violation W331 citing 42 C.F.R. § 483.460(c)), attached as Exhibit 8, pages 8-11.


30 42 C.F.R. § 483.460(a)(1).

31 RCS SOD and POC for survey dated 1/6/2017, Rainier PAT C (finding violation W189 citing 42 C.F.R. § 483.430(e)(1)), attached as Exhibit 3, page 9-10.

32 RCS SOD and POC for survey dated 1/6/2017, Rainier PAT C (finding violation W189 citing 42 C.F.R. § 483.430(e)(1)), attached as Exhibit 3, page 9-11.

33 Under federal law, Rainier 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 …” 42 C.F.R. § 483.440(a)(1).

34 Under Washington State law, the RHCS (including Rainier) 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.

36 Supra note 34.


38 Letter from Candace Goehring, Director, RCS, to Administrator/Superintendent, Rainier School PAT E, (Sep. 8, 2017), attached as Exhibit 1.


40 See supra note 37.

41 RCS SOD and POC for survey dated 5/31/2017, Rainier PAT A (finding violation W196 citing 42 C.F.R. § 483.440(a)(1)), attached as Exhibit 9, page 22-35.


47 See 42 C.F.R. § 483.440(a)(1).

48 Supra note 46.


50 Letter from Candace Goehring, Director, RCS, to Administrator/Superintendent, Rainier School PAT E, (Sep. 8, 2017), attached as Exhibit 1; letter from Steven Chickering, Associate Regional Administrator, Western Division of Survey and Certification, to Administrator, Rainier School Pat E, (Dec. 19, 2017), attached as Exhibit 2.


52 Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, RCS, to Jeff Flesner, Acting Superintendent, Rainier School PAT C (Dec. 4, 2017), attached as Exhibit 10; and RCS SOD and POC for survey dated 12/1/2017, Rainier PAT C (finding violation W102 citing 42 C.F.R. § 483.410, W104 citing 42 C.F.R. § 483.410(a)(1), W186 citing 42 C.F.R. §
483.430(d)(1)), attached as Exhibit 11; Letter from Gerald Heilinger, Field Manager, ICF/IID Survey and Certification Program, RCS, to Jeff Flesner, Superintendent, Rainier School PAT A (Oct. 6, 2017), attached as Exhibit 12.

53 Supra note 4.

54 The video recorded by investigative reporter Geraldo Rivera can be viewed at his webpage: http://geraldo.com/page/willowbrook (last viewed Jan. 5, 2018).

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