Exhibit A
INTRODUCTION

In April 2018, Westcare Management, Inc. was contacted by Donna Cobb, acting Deputy AG within the State of Washington, DSHS, regarding Westcare’s interest in performing a Root Cause Analysis (RCA) report and a Corrective Action Plan Recommendation for the State’s Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/ID’s) in Buckley (Rainier—PAT E) and Bothell (Fircrest—PAT A), Washington.

Both ICF/ID PATs had recently been placed in Non-payment Status with CMS for continued non-compliance to ICF/ID Participation of Conditions. Neither of the two PATs had been able to get back into compliance and had gone beyond the 11 months of ‘No-Admission’ and sought a settlement agreement with the Washington Health Authority and CMS that included seeking an independent firm to complete the RCA and Plan of Correction (POC).

Based on this request, we performed the following analysis:

RAINIER RHC

Conditions Out: Governing Body & Active Treatment

OPERATIONAL REVIEW – Root Cause Analysis

An on-site visit began at Rainier RCH on May 21, 2018. A tour of the campus was conducted by Pat Brockelman, Assistant Superintendent, and time was spent reviewing the current operations with Jeff Flesner, Rainier Superintendent, Mick Pettersen, Medicaid Compliance Administrator; and Charlie Weedin, Deputy Assistant Secretary. Discussions included our initial impressions of the detailed document review we had completed prior to the on-site visit and where we would need to begin the observations, records review, and staff interviews.

The observations, staff interviews, and records review occurred between May 21 and June 1 and again between June 11 and June 15. Observations were conducted in the homes, at the Adult Training Program (ATP), on the campus grounds, at the
Rainier Store Gift Shop located in the City of Buckley, and in the PAT E Administration Office.

Rainier staff interviews were completed with the individuals living in PAT E group homes, Attendant Counselors 1, 2 & 3 (AC Staff), Attendant Counselor Managers (ACM Staff), Habilitation Plan Administrators (HPA Staff), Developmental Disabilities Administrator 1 (DDA1) and the Developmental Disabilities Administrator 2 (DDA2—also referred to as the PAT Director), Registered Nurses (RN’s), Licensed Practical Nurses (LPN’s), Psych Associates, Adult Training Staff 2, 3 (ATS Staff), Adult Training Supervisors (AT Supervisor) Adult Training Director (ATP Director), Administrative Support Staff, Physical Therapist (PT’s), Occupational Therapists, Speech/Language Techs (SLP Techs), Quality Assurance (QA), Medical Doctors, the Superintendent and Assistant Superintendent. Additional interviews were completed with Developmental Disabilities Administration (DDA) Central Office Supervisory and oversight staff, Quality Measurement Team (QMT), IT, Maintenance, and the RCS Supervisor and his team of surveyors.

Record review consisted of comprehensive functional assessments (CFA’s), Individual Habilitation Plans (IHP’s), written program plans, HPA, Psychology Associate (Psych), and ACM monthly and quarterly summaries, medical charts (referred to as the “Red Books”), programming books in the home (referred to as the “Blue Book”), training curriculum, policy and procedure, job descriptions, memos, organizational charts, Federal 2567 Statement of Deficiency (SOD’s), and Plans of Correction (POC’s).

On May 22, a ‘task-force’ was created that initially involved AC Staff, ACMs, HPAs, Developmental Administrator 1 (DDA1) and DDA2, Jeff Flesner, Sarah Tunnell, and us to complete a Root Cause Analysis, to create ‘buy-in’ from the PAT E Staff, and to begin to create a cross-departmental dialog within PAT E. This Task Force met daily for the first week and then determined to meet regularly on Wednesdays at 2:00pm. As the RCA progressed, the Task Force added individuals from Psych, Nursing, Occupational Therapy (OT), SLP, the Adult Training Program, and so on as the focus changed from Root Cause to a Plan of Action.

Using the data and information collected and using a culture survey completed by PAT E (AC’s, Management, and Professional Staff), a Root Cause Analysis was
produced for each Condition of Non-Compliance (Governing Body & Active Treatment) based on a fishbone diagram method, The Five Why’s, and then prioritized using the Pareto chart method. A draft root cause table based on those findings was published and distributed to the Superintendent, Jeff Flesner and to DDA Staff; Charlie Weedin, Debbie Roberts and Evelynn Perez. A copy of it was also forwarded to Deputy Attorney General Donna Cobb and Kate Kreuger, Gerald Heilinger from RCS and Julius Bunch, CMS Region 10. The Final Copies of each root cause analysis are attached as Appendix A (Governing Body RCA) and Appendix B (Active Treatment RCA), and a media copy in Microsoft Word has been supplied to the facility.

Governing Body

Summary of Findings

The condition of Governing Body was initially cited in because of the Condition of Active Treatment not being corrected from the previous survey. RCS did not see any good faith effort in the attempted correction of the Active Treatment condition and the continued deteriorating physical condition of Rainier State Residential Habilitation Center (RHC). Rainier has three levels of Governing Body; Central Office (which includes the DDA and to a lesser direct extent, both the Department of Social and Health Services and Washington State’s Legislative Committees that request, approve, and provide oversight of the financial operation of the RHC’s), Rainier State RHC (Rainier’s Superintendent), and PAT E (DDA2).

Upon arrival, we observed that a written policy outlining the responsibilities of each level of the governing body could not be produced. What we observed were many instances of organizational chaos; constant and many times contradictory directives from DDA, confusion of roles and weak leadership at Rainier, confusion about the chain-of-command between DDA and Rainier including within PAT E itself, a general lack of responsibility for decision-making from any level of governing body, and PAT E staff who were frozen, cue dependent and frustrated.

Rainier has not had strong consistent leadership, having four different Superintendents within the last 15 years. The last three (including the current
Superintendent) had little to no working knowledge of the Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/ID).

In 2009, during the Washington State revenue downturn and resulting budget crisis, many Direct Care (AC staff) staff positions were cut, leaving a general staff: client ratio at a 1:6. This level of staffing does not meet the basic level of expected staffing (based on the reg w187—the rule of thumb is a 1:3 staff: client ratio); it also cannot meet the Active Treatment needs listed in each individual’s Individual Habilitation Plan (IHP) indicated in w186.

During this 2009 crisis, Qualified Intellectual Disabilities Professional (QIDP) positions in the facility were changed from Social Workers acting within a QIDP scope to Habilitation Plan Administrators (HPA’s). HPA positions were cut and lost to attrition and the case load became overwhelming at 30-32 individuals, which is double the amount we recommend an average QIDP (or HPA) can effectively manage. As a result, much of the paperwork and needed care management suffered. The response to this problem was to split HPA duties with the Attendant Counselor Manager (ACM), pulling ACM’s off the floor and actively overseeing and training staff, to do assessments, write programs, and monitor programs for change (monthly summaries). The HPA’s would then read the ACM summaries and write their own quarterly summary based on those summaries. None of the ACM’s being taught how to write and monitor programs based upon the regulations, nor were many of them QIDP qualified to do so in their education. This is more thoroughly discussed in the Active Treatment section of this report.

The 2009 legislative season brought about more difficult decisions that siloed off many departments. The Department of Social and Health Services (DSHS) created the conditions for these ‘siloes’ by bringing maintenance, transportation, financial services, IT, and HR out from under Rainier and DDA’s direction to being centrally driven from DSHS itself; limiting what the Superintendent could do to counter an aging and obviously out-of-use campus. Those decisions made almost 10 years ago have starved Rainier from essential updates (including the implementation of electronic records, maintenance projects and adequate funds for professional and direct support staff it requires to achieve and then maintain ICF compliance).
In general, over the past decade and a half, Rainier has drifted far from the ICF model the regulations expect. Regulation training and understanding retired along with those who had been knowledgeable of the regulations. During that same time-period, Pat E had remained in condition and believed it to mean they had been following Federal regulations. Unfortunately, that had not been the case. In 2014, Residential Care Services (RCS) had been cited by CMS as needing further guidance in their interpretation of surveying Active Treatment. RCS then attempted to make clear to all ICF’s operating within the State of Washington the new interpretations. RCS provided two training opportunities to Rainier RHC itself with little follow-through noted from Rainier. Additionally, during this time (2015) the ICF/ID Guidance to Surveyors was also updated, changing many interpretations State Agencies and Providers had held prior to that—placing Rainier even further behind in their ability to catch up to current, expected ICF practice. PAT E failed to get back in to compliance after their 11-month admission freeze, primarily due to a view from PAT E leadership and programmatic staff that they could correct this by themselves; not understanding the rule changes and updates to the survey process. DDA aggressively attempted to intervene in the day to day operations and program development at PAT E to try and correct the issues, but this led to circumventing the Superintendent. DDA’s intervention was done without complete understanding of the regulations or understanding of how their own State Agency (RCS) interpreted the regulations and new guidance. DDA’s use of one staff person as the Subject Matter Expert, through which all policy, forms, and training approval flowed, but as with other sections in DDA, they did not have a complete knowledge of the regulations, requirements, and interpretations of the rules and methods. This has led to struggles between DDA’s direction and RCS’s guidance. The general relationship between Rainier and DDA appears at times as confusing and contentious; with DDA employees openly speaking negatively about their thoughts of Rainier Leadership and vice-versa. There is a need to rebuild trust in this relationship to act as the foundation for long-term strengthening of this Governing Body’s role in caring for clients.

**Plan of Correction**

**Recommendations Made and Implemented During RCA Process**

1. Suggested that DDA cease its current interaction and implementation of new policies, forms, QMT’s, QA’s and projects at PAT E and that direction between non-supervisory support DDA staff and PAT E employees go
through the chain-of-command touch points (Rainier Superintendent & the Deputy Assistant Secretary—initiated June 29th, 2018

a. Reason: to simplify the corrective actions needed to align PAT E’s systems and processes (being sent from DDA) with the ICF regulations
   i. Status: DDA staff have pulled back issuing directives, forms, policy implementation, and program changes to PAT E

b. Reason: the observed organizational flow was causing confusion at the PAT and Rainier levels with multiple inputs from DDA directly to PAT employees without the engagement of the Superintendent
   i. Status: DDA has begun issuing operating directives to Rainier from the Deputy Assistant Secretary to Rainier’s Superintendent and vice versa, reducing confusion
   ii. Status: DDA has offered the necessary support, including resources and policy changes Rainier has requested

2. Suggested that DDA re-establish positive communication with the RCS (surveyor agency)—initiated June 29th, 2018

a. Reason: All levels of the Governing Body appear to have developed a negative, view of the RCS staff based—in part—on the information they were getting back from the RHC’s about potential surveyor misbehavior (the falsification of findings with one specific surveyor), and because the survey itself seemed to get much more difficult because of changes in the compliance expectations. This blame was improperly aimed at the RCS staff for ‘being too critical’ and ‘changing the game up’ and this was why they couldn’t get back into condition. The reality is that RCS is responsible to interpret the federal ICF regulations and have been working closely with CMS over the past couple of years to assure that they are interpreting the regulations as directed by CMS.
   i. Status: The Deputy Assistant Secretary and the RCS Supervisor report they are engaged in weekly calls with each other in a good start to lessening suspicion and creating a healthy relationship between the department responsible to assure the implementation of the ICF regulations and the department responsible for the interpretation and monitoring of the ICF regulations
3. Suggested Regulation Training for the Superintendent, Assistant Superintendent, Pat E Director, Medical Director, Nursing Director, Quality Assurance, DDA’s Quality Management Team and other key leadership staff
   a. Reason: The great majority of DDA, Rainier and PAT E staff have had little to no training on the ICF federal regulations. The training they did receive was created by individuals who’s working knowledge of the regulations was not erudite enough to understand how the regulations work, how to identify potential non-compliance and how to fix problems.
      i. Status: Every PAT E employee received an updated Active Treatment training; every PAT E professional employee have attended the Interdisciplinary Treatment Team trainings. Leadership (both Rainier and DDA) have taken the CMS basic surveyor training (with the updated Task 2 process included). Guided training also occurred in 93 actual IDT meetings. Individualized Habilitation Program training has been provided to each HPA and program writing training is scheduled to begin August 3rd with every HPA.

**Immediate Actions (As soon as possible):**
1. Complete an accurate Governing Body Policy for all levels of GB Functions
2. DDA should review its own organizational structure (the one practiced and not the one on paper) and establish who directly oversees Rainier RHC—and make that clear to Rainier Leadership and DDA’s own leadership and support staff
   a. Many DDA ‘support staff’ take on the ‘direct’ oversight role for themselves and have treated Rainier staff as subordinates that must comply with whatever they have determined appropriate—even if it directly contradicts the regulations. This has caused chaos, anger and confusion for PAT E, Rainier, and for DDA itself
      i. Status: DDA has pulled their ‘support staff’ from interfering in this process and has clarified that Deputy Assistant Secretary, Debbie Roberts is Rainier’s DDA direct report. We have observed this implementation at the facility level
   b. DDA should be very direct with the Superintendent about his expectations, make sure he knows who he is accountable to, and
then hold him accountable for following through with those expectations

3. Rainier Leadership should make having a working knowledge of the ICF regulations the foundation of every position
   a. From food service staff to the Medical Director and Superintendent—everyone should understand their position and how it relates to the regulations and the individual implementation of each client’s Active Treatment program
      i. Status: IDT Training Meetings and Active Treatment Training have been provided to all, as well as discipline specific regulation training to the different disciplines
   b. Rainier leadership must be able to review any policy and/or instruction against the ICF regulations to assure compliance to the regs
      i. Any regulatory disagreements can easily be solved by contacting the State Agency (RCS) for guidance and clarification (Best Practice)
      ii. Status: Adjusted assessments have been turned into RCS for comment prior to implementation as an example of how the State Agency can help better inform providers on the interpretations of the relevant regulations

4. Progressive Employee Discipline
   a. Review the current Progressive Discipline policy for the any implementation barriers managers experience
      i. Status: New Recommendation
   b. Hold managers accountable to this policy instead of placing poor performers on alternate assignment or changing them to other departments
      i. Status: Ongoing. Note: Rainier does typically hold AC staff much more accountable then the professional/supervisory class of employees

**Long-Term Recommendations**

5. Investment into Rainier: If Rainier is to remain an ICF/ID, the campus and living facilities need to be updated to promote Active Treatment
   a. Assure appropriate training environments including:
      i. Remodeling kitchens to enable the daily meal prep and cook in the houses themselves
ii. Remodeling in each home for privacy during Med Times

iii. Making the laundry facilities at the home (two sets of laundry equipment on both sides of each home)

iv. The development of ‘Home Budgets’ that would allow each home to do their own food shopping in the community with the clients
   1. The food the clients eat is unpleasant and it likely shows in weight loss for some (its taste) and weight increase in others (its many types of carbs and starches and sugar—fresh fruits or vegetables could not be found in any of the observations)
   2. Establish a family style meal situation that includes staff eating the same food at the table along with the clients, modeling appropriate meal interactions

v. Assuring each home has at least one vehicle
   1. Note: our private ICF’s would have 3 vehicles per a home with 15 folks

vi. Investing in work areas and pre-voc areas to better address the need for “real-world” vocational training

vii. Electronic Records and SharePoint Development based on the Individual with access to ALL the Interdisciplinary Disciplinary Treatment Team
   1. Critical for:
      a. Medical Records
      b. Treatment Records
   2. Best practice would include:
      a. Programs, progress notes, and data
      b. Look at licensing each home with its own ICF license instead of one licensed for each PAT
         i. Licensing per home is much easier to manage then the PAT system
         ii. It is much easier to get one non-compliant home back into condition then it is to get a whole PAT back into condition because of one difficult home or a few outlier individuals.

6. Leadership
   a. Leaders at the Rainier, PAT and home levels require ongoing leadership training and mentorship
i. Establish a Leadership Philosophy, train to it, and hold leaders accountable to it
   1. The Leadership Training available from Human Resources is very cursory and doesn’t provide any type of mentor to help guide a new leader
ii. Status: Due to gaps in leadership and effective management, successful and continued stability remains a concern after Westcare’s exit from Rainier
b. Rainier Superintendent: The Superintendent needs more leadership training and skill building before he will be able to successfully lead Rainier. This should not affect the short-term outcome of PAT E’s upcoming survey but becomes much more of a barrier to long-term sustainability.
c. PAT E Director: The Director has played key roles for the implementation of the Task Force related projects (key in this process). He tends to vent ‘downwards’ in any environment; from key meetings to casual conversations. He would also benefit from more leadership training and skill building as his current behavior and skill level will become a barrier to long-term stability
   i. Additional note: the DDA1 in PAT E is nearing retirement and appropriate succession has not yet been identified, potentially leaving PAT E with less skill and leadership, becoming a risk to long-term stability

Active Treatment

Summary of Findings

The condition of Active Treatment was initially pulled because of a breakdown of the Active Treatment process beginning at the Individual Habilitation Plan (IHP) phase of the Active Treatment Loop process. The IHP did not accurately reflect the Comprehensive Functional Assessment (CFA) and the programs could not be traced back to the IHP or the CFA. Program monitoring by the Habilitation Plan Administrator (HPA) was not occurring and was monitored and analyzed by the Attendant Counselor Manager (ACM). ACM’s are not trained as Qualified Intellectual Disabilities Professionals (QIDP) and are not actually qualified to complete the QIDP work. The ACM’s did not prioritize enough goals (either
formally or informally) to be able to provide a robust active treatment schedule to clients and the programs that were prioritized were not assessed as a need in the CFA. Upon their return, RCS did not see good faith effort in the attempted correction of the Active Treatment condition and they remained out of compliance.

Upon the initial visit, record review, and interviews, we were able to confidently identify that the breakdown in the Active Treatment Loop began at the Comprehensive Functional Assessment (CFA) and the Interdisciplinary Treatment Team (IDT) phases. Habilitation Plan Administrators (HPA), ‘trained’ as the Qualified Intellectual Disabilities Professional (QIDP), were not receiving even minimal interaction from other disciplines. Frequently the HPA would not receive any assessment from the other disciplines, nor did most disciplines attend the IDT Individual Habilitation Plan meeting. The HPA’s were completing the missing assessments largely by themselves (out of scope, but anxious to get the information into the client’s plan). The outcome of this practice caused confusion within the Active Treatment Loop Process at PAT E. From the broken CFA (which by itself would cause enough problems to be taken out on condition), the IDT team functioned as a completely separated and siloed multidisciplinary treatment team. No assessment informed another and so on, making treatment scarce, disjointed, and unreliable. Outcomes from this disjointedness have been observed many times on PAT E, with some being serious.

The prioritization of the Individual Habilitation Plan is the next step in the Active Treatment Loop. According to the regulations, prioritization of informal and formal goals is to be determined by the IDT team based upon the CFA. At some point, PAT E had been given the instruction to address “core needs”, based on a different treatment model than that of an ICF/ID. Core needs were addressing deficits not identified or not consistent with the CFA. Additionally, only a few at a time became formal programs. Upon the initial survey, RCS cited these as examples and tried to push the teams to understand that robust active treatment could not occur with so many assessed needs not being addressed. There is not a number that the regulations require, but they do offer some good guidance in w242 about what should be formally addressed. When RCS came back for the follow-up, they did not see the robustness that is described in the definition of Active Treatment located in the regulations w195, nor did they see the critical
w242 needs being addressed (or money management and self-administration of medication training programs).

The next phase of the Active Treatment Loop is program writing and implementation. In many cases this was the Attendant Counselor Manager’s (ACM’s) task. None of the ACM’s were trained as an HPA and had not attended the HPA Academy that teaches beginning program writing. Even though the HPA Academy was started because of an observed lack of HPA QIDP skill sets, none of that training met program requirements because the people writing the programs had not been identified as the ACM at the time. It is important to note that the regulations allow for non QIDP staff to write programs, but the QIDP (HPA) is still responsible for the content and regulatory compliance. In general, HPA’s had no knowledge of what programs their assigned individuals were working on, how they were doing with that goal, and what was next on the horizon for them. As far as implementing a program, typically the program would come out with a training memo that all staff needed to read and sign that they read and acknowledged they were now responsible to implement the program correctly. Because of the unbalanced work load of the ACM’s, they didn’t have the time needed to train staff on the floor (which is one of their expected job duties). They left that up to the AC3’s, who assigned it to an AC1 or AC2, who usually presented the trainee’s to the memo to read and sign that they were now trained. Based on how new programs were taught and now how far removed the objectives were from the assessed needs, data collection was unclear and not complete. In what may have been a way to limit the lack of data exposure, many ACM’s reduced the amount of data collection required in the program instructions—sometimes down to once per month for tasks that have opportunities to be implemented daily. Monitoring these programs with such a limited data set is bad practice and is not sufficient enough to claim Robust Active Treatment, even if they were attached to an assessed need. These were just some of the examples of deficient program monitoring practices.

ACM’s were also the active monitors of the progress or regression of the written program plans. In the regulations, the analyzing of data is a specific QIDP (HPA) that cannot be delegated to non QIDP staff. In failing to assure this, monitoring a program depended on the ability of one ACM to understand the entire regulatory process. ACM’s relied on their own limited understanding of their IDT role. If all other phases of the Active Treatment Loop were rolled out according to the regs,
having an ACM monitor and change programs would break that process loop on its own. This is consistent with what we observed in interviews, records, and observations. Program objectives were being met but remained unchanged. Program objectives that were not being met, were increased in skill difficulty. Programs objectives that were not implemented correctly and were not being identified. Objectives that were too difficult for that individual were not adjusted, and so on down the line, until the information made its way back to the Comprehensive Functional Assessment and falsely informed the process all over again. The details of the findings can be found on Exhibit B of the attachments.

**Plan of Correction**

**Recommendations Made and Implemented During RCA Process**

1. **Staffing**
   a. Rainier is aggressively recruiting Attendant Counselors, Adult Training Staff, Rec Staff, QIDP’s (HPA), Psychologists, Occupational Therapists, and a list of other Professionals
      i. The critical nature of hiring the necessary AC staff to bring the overall ratios to at least a 1:4 staff: client ratio has been highly prioritized
      ii. Status: aggressive hiring is occurring with all the New Employee Orientation Staff being trained in August and headed to PAT E for further aggressive on the floor training
      iii. These new AC staff will still be new staff when the final survey occurs—the expectation is that the professional and supervisory staff will be seen on the floor throughout this whole process actively teaching the new and seasoned staff the new plans and expectations all together

2. **Comprehensive Functional Assessments (CFA’s)**
   a. CFA to be updated by each discipline and into the HPA (QIDP)
      i. Status: except for the Occupational Therapist and one Psych Associate and a delay of the Health Care Assessments completed by the medical doctors, all assessments came in on time.
         1. The Occupational Therapist was granted additional time based on the amount of assessments needed and a lack
of other OT professionals at Rainier, however she has exceeded that amount of time and should have had the time to complete all the remaining PAT E assessments at this time.

a. The OT or one of her assistants did make it to every needed IDT meeting to assure they remained involved and to better inform what needed to change in their existing OT eval

2. The Psychological Associate went on vacation for two weeks to the lead up to the assessment due date but did come back prior to the due date and was available to complete the assessments for his two homes in the two weeks he had until his next scheduled 2-week vacation began. He did not get them completed and left the task to one of his peers to complete in his absence

a. The Psych Associate did make it to his assigned IDT meetings

3. Once informed of the changes to occur and the ICF expectations of the IDT team were made clear, the PAT E Medical Doctor submitted his resignation, leaving the Acting Medical Director to complete those required assessments. Those assessments are still being completed.

a. The PAT E Doctor that submitted his resignation was still able to attend all PAT E’s IDT meetings

3. Interdisciplinary Treatment Teams (IDT)

a. All the PAT E professional staff received a mandatory IDT training

i. Except for PAT E’s DDA1, but they were involved in the Task Force so were thoroughly exposed to all the same information presented in the Mandatory IDT Trainings

b. All IDT teams to schedule and attend a new IDT meeting for every PAT E client who did not have an annual meeting already scheduled in August

i. Status: All PAT E clients without scheduled IDT’s in August did receive a new IDT meeting

1. IDT’s were completed with guided training by Westcare Staff at the actual meeting, assuring that w242, Self-
administration of medications, and money management are addressed in the plan.

2. Full IDT Teams were expected and attended

4. Individual Habilitation Plans
   a. All IHP’s will be updated using the new assessments and using the full IDT team’s recommendations
      i. Status: Ongoing

5. Program Writing
   a. Program will be re-written by the HPA and the ACM will direct HPA (QIDP) oversight, trained on the floor by the HPA and ACM, and implemented
      i. Status: Ongoing

6. Program Implementation
   a. Upon implementation of written programs, a coaching team consisting of QA and Staff Development will be out in the homes and ATP, coaching (not monitoring) AC staff on Active Treatment and Program Implementation
      i. Status: Ongoing
   b. Professional and Management staff will be in the homes, coaching staff on the implementation of any needs their discipline is responsible for
      i. Status: Ongoing

7. Program Monitoring
   a. ACM’s have ceased writing monthly summaries and HPA’s have implemented a new QIDP Monthly Summary form they will complete monthly on every program for every assigned individual beginning for the data month of August
      i. Status: HPA’s and ACM’s have been notified of the change

8. Program Change
   a. Every change must be approved by the appropriate IDT members through the HPA, the HPA inserts the change into the plan, and the HPA monitors the effectiveness of the change then informs the appropriate IDT members of the results of the change or assesses for another revision
      i. Status: Ongoing
9. The Adult Training Program (ATP)
   a. Their ‘new’ program is only partially rolled out after 10 months of implementation
      i. The new implementation date is August 15th (coinciding with the roll out of the new program plans and Active Treatment Schedules)
   b. Program concentrates on ‘Classes’ done in a classroom setting & focuses on core needs (not prioritized needs)
      i. This was corrected in the individual’s IDT meetings
   c. The ATP program was not based on skill building
      i. The new ATP program is based on skill building, as well as pre-vocational and vocational activities and robust recreation options
   d. Status: ATP is still in the middle of structural program changes and will likely be in the midst of change by the survey date

10. Outliers (wanderers)
   a. These individuals were identified by their IDT team and interventions were discussed and determined within the individual’s IDT Meetings.
   b. Status: Associated plans are being rolled out and trained upon

Additional Comments and Recommendations
The State of Washington should determine Rainier’s future function and whether they need to devote additional resources to maintain the program. As an ICF, many structural changes will need to be made to keep within the spirit of the federal ICF program. We recommend the state look at what other states have done with their State Institutional model. Likely this will involve looking at the current model of Adult & Children services provided by private providers. It doesn’t appear that community providers (ICF/DD or Supported Living) are prepared to help the state with a transition out of institutions at this time.
FIRCREST RHC

Condition Out: Active Treatment

OPERATIONAL REVIEW – Root Cause Analysis

An on-site visit began at Fircrest RCH on June 4, 2018. A tour of the campus was conducted by Upkar Mangat, Assistant Superintendent, and time was spent reviewing the current operations with Megan DeSmet, Fircrest Superintendent. Discussions included our initial impressions of the detailed document review we had completed prior to the on-site visit and where we would need to begin the observations, records review, and staff interviews.

The observations, staff interviews, and records review occurred between June 4 and June 11 and again July 30. Observations were conducted in the homes, at the Adult Training Program (ATP), on the campus grounds, at the Coffee Shop (cafeteria) and the Administration Office.

Fircrest staff interviews were completed with the individuals living in PAT A group homes, Attendant Counselors 1, 2 & 3 (AC Staff), Attendant Counselor Managers (ACM Staff), Habilitation Plan Administrators (HPA Staff), Developmental Disabilities Administrator 1 (DDA1) and the Developmental Disabilities Administrator 2 (DDA2—also referred to as the PAT Director), Registered Nurses (RN’s), Licensed Practical Nurses (LPN’s), Psych Associates, Adult Training Staff, Physical Therapist (PT’s), Occupational Therapists, Speech/Language Techs (SLP Techs), Quality Assurance (QA), Medical Doctors, the Superintendent and Assistant Superintendent. Additional interviews were completed with Developmental Disabilities Administration (DDA) Central Office Supervisory and oversight staff, Quality Measurement Team (QMT), IT, Maintenance, and the RCS Supervisor and his team of surveyors.

Record review consisted of comprehensive functional assessments (CFA’s), Individual Habilitation Plans (IHP’s), written program plans, HPA, Psychology Associate (Psych), and ACM monthly and quarterly summaries, medical charts, programming books in the home, training curriculum, policy and procedure, job descriptions, memos, organizational charts, Federal 2567 Statement of Deficiency (SOD’s), and Plans of Correction (POC’s).
Using the data and information collected and using a culture survey completed by PAT A (AC’s, Management, and Professional Staff), a Root Cause Analysis was produced for the Condition of Non-compliance of Active Treatment based on a fishbone diagram method, The Five Why’s, and then prioritized using the Pareto chart method. A draft root cause table based on those findings was published and distributed to the Superintendent, Megan DeSmet and to DDA Staff; Charlie Weedin, Debbie Roberts, and Evelyn Perez. A copy of it was also forwarded to Deputy Attorney General Donna Cobb and Kate Kreuger, Gerald Heilinger from RCS and Julius Bunch, CMS Region 10. The Final Copies of each root cause analysis are attached as Appendix C (Active Treatment RCA), and a media copy in Microsoft Word has been supplied to the facility.

Active Treatment

Summary of Findings

The condition of Active Treatment was initially pulled because of a breakdown of the Active Treatment process beginning at the Individual Habilitation Plan (IHP) phase of the Active Treatment Loop process. The IHP did not accurately reflect the Comprehensive Functional Assessment (CFA) and the programs could not be traced back to the IHP or the CFA. Program monitoring was not occurring by the Habilitation Plan Administrator (HPA) but was monitored and analyzed by the Attendant Counselor Manager (ACM). ACM’s are not trained as Qualified Intellectual Disabilities Professionals (QIDP) and are not actually qualified to complete the QIDP work. The ACM’s did not prioritize enough goals (either formally or informally) to be able to provide a robust active treatment schedule to clients and the programs that were prioritized were not assessed as a need in the CFA. Upon their return, RCS did see systems were well on their way to being corrected, but that Fircrest still had much to do yet with their Outliers (those individuals for whom Active Treatment is difficult to identify and implement) as well as their Day Program and Adult Training Program failing to provide individual skill building opportunities and meaningful activities. Due to these continuing issues they remained out of compliance.

Upon our initial visit June 4th through the 11th, from observations, record review, and interviews, we were able to identify that for many, the active treatment
process was intact. We saw continuing issues with the new HPA’s still learning their QIDP role, outliers still largely out of compliance, and their Day Program and Adult Training Program still out of compliance for individuals not working on one of their several work crews. Programmatically, the Comprehensive Functional Assessments failed to address the needs of those who are functioning on the higher end of the spectrum (more independent) as well as those functioning on the lower end of the spectrum (less observable abilities). The HPA’s had been prioritizing too few objectives based on those CFA’s to meet the “robust” part of the Active Treatment Definition and expectation. The interdisciplinary treatment teams function more like a multidisciplinary treatment team, with each discipline specific assessment failing to inform or to be informed by the other disciplinary assessments. The IDT meetings, (which did have most of the treatment team members in attendance), failed to engage in the rigorous and robust debate needed to develop an individualized and meaningful treatment plan needed for that individual to be able to realize his or her highest potential in the least restrictive environment necessary. HPA’s were still struggling, though identifiably better than what was noted in the SOD, writing single behaviorally stated measurable objectives. Additionally, staff instructions were too few and vague and data collection requirements too few to get a reliable monthly sample. HPA’s were also failing to sufficiently analyze for trends or concerns in the monthly data and Q-Summaries. When an individual was failing to meet an objective HPA’s would discontinue the program instead of analyzing the efficacy of the program and staff instructions to make the necessary changes. Frequently, after discontinuing the program, HPA’s wouldn’t prioritize another objective in its place. If the individual started out with 7 training programs at the beginning of the year, they ended the year with far less than that (we observed individuals with two formal objectives). That fails to meet the “robust” expectation of the Active Treatment definition.

**PLAN OF CORRECTION**

1. CFA to be updated to address the needs of each end of the functioning spectrum and in to Q by each discipline
2. All IDT Teams should review the CFA in total to assure each discipline’s needs are addressed in the IHP
3. Ongoing IDT training for all IDT members
a. We completed IDT meeting/trainings with HPAs with five of Fircrest’s “outliers” (high functioning individual whose IHP plan was failing to address her needs) as a training.

4. IHP’s should be updated to include w242 Adult Living Skills, Money Management needs, and Self-administration of Medications as appropriate to the individual.

5. Programs updated to include:
   a. single, behaviorally stated, and measurable objectives
   b. Appropriate staff instruction

6. Monthly QIDP Summaries should be reviewed and analyzed by the HPA to determine if staff are understanding/implementing/collecting data correctly and to root cause any problems and to identify trends and patterns

7. HPA’s require Basic and ongoing QIDP and regulatory training
   a. CMS has a provider portal for regulation training

8. Each IDT must identify the “outliers” and meet as a full IDT team to assure assessments are updated and address the needs of each of these individuals
   a. New programming addressing the newly assessed needs must be implemented with training
   b. The Active Treatment Schedules of these individuals must also be updated and implemented

9. ATP/Day Program
   a. Increase opportunity for involvement on work crews as much as possible
   b. Implement meaningful skill-building opportunities in the classrooms
   c. Look for employment opportunity within the community
   d. Look to incorporate retirement activities within the community
   e. Look for volunteering opportunities for individuals within the community
   f. Whole program was rolled out on August 6th and is still working out some barriers

10. The State of Washington should determine Fircrest’s future function and whether they need to devote additional resources to maintain the program. As an ICF, many structural changes will need to be made to keep
within the spirit of the federal ICF program. We recommend the state look at what other states have done with their State Institutional model. Likely this will involve looking at the current model of Adult & Children services provided by private providers. It doesn’t appear that community providers (ICF/DD or Supported Living) are prepared to help the state with a transition out of institutions at this time.
## GOVERNING BODY

<table>
<thead>
<tr>
<th>Current Process Issues</th>
<th>Status</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>No written Policy on who the Governing Body is &amp; what roles they play (This is a structural tag, meaning GB is either there or it is not—no shades of grey)</td>
<td>Correction Action Initiated — Informed Central Office of lack of a Governing Body Policy, role confusion, and org structure chaos</td>
<td>Write and implement a Governing Body policy outlining the responsibilities of each member at their respected level.</td>
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<tr>
<td>The physical environment and the failure to provide the necessary regulatory guidance and training on Active Treatment are the reasons Rainier came out of Governing Body Status</td>
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<tr>
<td>Central Office (CO) is responsible for the maintenance of the campus and approving work orders in a timely fashion</td>
<td>Correction Action Not Initiated</td>
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<td>Central Office oversees IT and any problems relating to IT</td>
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<tr>
<td>Central Office has many “satellite” departments that directly interact with and direct PAT employees instead of the superintendent</td>
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<tr>
<td>Central Office is responsible for direction and support; its current support and direction contradict or misinterpret the regs (see POLST, Individual Habilitation Plan (IHP), Critical Incidents Notification Memo, Active Treatment Survey Monkey Questionnaire for examples)</td>
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<td>No clear and regulatory based direction given to the superintendent in response to the emerging crisis at Rainier.</td>
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<tr>
<td>Central Office (CO) requires all forms and policies, and Plan of Corrections (POC’s) to be approved through their own process, often significantly delaying timely implementation of needed interventions or actions</td>
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<tr>
<td>CO relies on a single staff to interpret Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/ID) regulations for the entire state. This single person located away from care and survey becomes a weakness due to lack of hands-on experience and no outside opinions. The Subject Matter Expert (SME) in any field requires at least 10,000 hours of intensive training &amp; practice.</td>
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### Exhibit A Rainier RHC

- Does not have positive working relationship or trust in Rainier's SME (Sarah Tunnell) who is truly the expert in not only the regulations, but also the survey process with specifically Rainier.
- The relationship CO has with Rainier can be categorized as contentious and competing. It is a suspicious relationship, lacking meaningful and often confusing support that takes up significant time of the leadership at Rainier and at the PATs.
- Many times, the Superintendent is kept out of the decision-making authority loop and by-passed all together.
- The chain-of-command is clear on paper but see the attached Rainer Org chart as how it is observed to be practiced.

As a matter of practice, CO fails to seek RCS' regulatory input concerning changes in policies, programs, and training (This is a regular function of state agencies).

- Many CO staff openly voice their displeasure and lack of confidence in the Superintendent – note: it is not the same Superintendent that lead Rainier into its current crisis, he came on after and only in a temporary position.
- Central Office hires the Rainier superintendents; none of which were expected to understand the ICF regulations or knew how to identify and correct ICF regulatory deficiencies.

#### Superintendent

- Temporary Position
- Been acting Superintendent for 1 year
- Because of a lack of working ICF regulation knowledge, he has been easily led down paths that further challenge the implementation of the ICF regulations.
- Staff see him as a good person, but weak leader.
- Has not received adequate leadership or regulatory training.
- Has not held individuals or departments accountable for continued poor performance—uses alternative assignment, or re-assignment instead of progressive discipline and/or termination.
- Decisions had to be cleared through a Central Office contact, without any actual authority over Rainier operations, before implementation.
- Unions can complicate the needed performance correction of an employee.

#### Correction Action Initiated

- Training regarding basic regulatory knowledge and current regulatory failures is in process. In addition, the Superintendent is establishing training for professional staff based on the identified regulatory needs of Rainer. This is being done in accordance with those whom have a strong regulatory background. This is ongoing and should continue throughout his time of the leadership at Rainier and at the PATs.
Exhibit A Rainier RHC

**PAT E**
- Director is frequently overwhelmed and emotionally reactionary
- Director has received very little leadership training and has only recently begun to receive regulatory training
- To implement all the contradicting directives, many of his subordinates have become overwhelmed, frustrated, exhausted, and frozen
- The Director jumped from being a Habilitation Plan Administrator (HPA) for less than a year at Rainier to the PAT E Director, which did not seem to include proper training for the position.
- The prevailing belief is that favoritism is the key to promotion and if true, that practice has damaged selecting the right people for positions based on merits and ability
- Progressive Discipline, up to and including termination, isn’t the normal corrective action on the PAT. Typically the individual gets re-assigned to other departments or goes on Alternate Assignment

**Correction Action Initiated**
- Training regarding effective leadership and leadership qualities.
- Clear guidance from limited sources on the direction and implementation of processes. Filtering through the Superintendent or Assistant Superintendent in accordance with the overall shift and goal of Rainier.
- Continuous and ongoing training regarding regulatory compliance

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<tr>
<th>All Levels of Governing Body</th>
<th>Correction Action Initiated</th>
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<tr>
<td>• Rainier has not functioned as an ICF/ID for many years</td>
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<td>• Failure to identify or act upon the gross dysfunction of the IDT</td>
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<td>• Failure to identify or act upon the dangerous medical practices</td>
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<td>• Regulations are not a training topic for professionals holding key positions (example: Doctors, Nursing, HPAs, Superintendent, ACMs, DDAs)</td>
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<td>• Lack of planning for loss of regulatory knowledge due to retirement, termination, or separation of key employees</td>
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<td>• The role of the HPA has drastically diminished over time.</td>
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<td>• Lack of attention on the impact of duplicated and convoluted processes (example: Implementation of a mandatory IDT Training with little regards to an IDT Training that had been scheduled, misleading and mixed messages from multiple CO staff that filter around the Superintendent to subordinates leading to disorganization and flawed implementation of the process, continuous and ongoing changes campus wide as a reaction instead of evaluating each specific incident.)</td>
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<tr>
<td>• Lack of on-going training to professional and non-professional staff on regulatory requirements, job duties, and continuous change with the survey process.</td>
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<td>• Informed CO and Superintendent of serious medical concerns regarding the medical silo on 5/21/18.</td>
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</table>

- IDT Training was completed on 6/15 and 6/18. 
- Professionals holding key positions require basic regulatory training regarding ICF/ID and the intent/goal of the requirements. All Professionals holding key positions should have basic regulatory training upon hire as part of their new hire process/training. This should include what an ICF/ID is and what their responsibilities entail. Continuous and ongoing training regarding regulations is a must. 
- Medical records for each individual should be reviewed and updated to state the individual’s current medical status, needs, and concerns. In addition, the audit should also look for inconsistencies within the record, missed or lack of follow through with lab work or other medical procedures or recommendations. Medical records must be shared with other...
members of the IDT Team as the regulations require. A siloed medical department and medical records leads to disruption in the Active Treatment process thus inhibiting the progress of the individuals served.
### Active Treatment Loop

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<tr>
<th>Active Treatment Loop Stage</th>
<th>Current Process Issues</th>
<th>Status</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **CFA**                     | - Assessments aren’t completed by each discipline  
- HPA Improvises & completes missing assessments  
- CFA is inaccurate, thus IHP is inaccurate     | Correction Action Initiated | CFA to be updated & in to Q by each discipline by July 13th.        |
| **IDT**                     | - No robust interaction b/ disciplines—silod off  
- In practice, IDT meetings aren’t considered as important as other meetings  
- Most Disciplines do not attend IDT meetings  
- ACM’s, HPA’s, and client are the only ones to typically attend the IDT & rubber stamp their own work | Correction Action Initiated | All IDT Teams will hold an IDT addendum meeting by July 27th (mandatory) |
| **IHP**                     | - Based on an incomplete CFA & IDT  
- IHP format is very brief and incomplete  
- Content is not a mirror reflection of the individual  
- W242 has been widely neglected | Correction Action Initiated | IHP’s will be updated by August 3rd to include w242 needs (SAMS & Money mgt) |
| **Program Writing**         | - Written by ACM’s w/o training with little to no Q oversight  
- Objectives are not behaviorally stated with single measurable objectives  
- Staff instruction isn’t clear, staff tend to copy what the person before them did  
- Programming is not geared towards achieving highest individual functioning level | Correction Action Initiated | Programs re-written by ACM’s & Q’s w/ Direct Q Oversight & implemented (trained) on the floor by August 15th |
| **Program Monitoring**      | - ACM’s monitor monthly (or weekly) & Q’s monitor quarterly  
- Changes that occur b/ quarters are not relayed to the Q’s until the next quarter  
- Q is often left out of knowing where the client is at in their treatment | Correction Action Initiated | Q’s review monthly, based off data & other discipline monthly summaries beginning for August summaries due in September |
| **Program Change/Update**   | - Changes are occurring in all disciplines, very few get to the Q to integrate the change into the plan  
- IHP no longer reflects the status of the client  
- Q isn’t monitoring if client reaches a goal or doesn’t, ACM makes changes based on the “grid”  
- CFA, IHP, programs no longer match | Correction Action Initiated | Every change must be approved by the IDT through the Q, Q reinserts the change into the plan, begins with this recommended process |
<table>
<thead>
<tr>
<th>Category</th>
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<th>Recommendations</th>
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</thead>
</table>
| QIDP     | - HPA not functioning as full Q  
- 2009 legislative cutbacks hit Social Workers functioning as Q's  
- Had a case load of 32 individuals  
- Q position was split up amongst ACM’s & HPA’s  
- HPA’s were no longer trained on or relied on reg guidance | - No one is coordinating active treatment | Corrective Action Not Initiated | Initial Q reg training (Basic Surveyor Training—CMS), ongoing Q training, culture change at Rainier and at Central Office in regards to the Q position. Strengthen Q’s professional authority in policy and in practice. Change position back to QIDP from HPA. |
| Staffing | - 2009 budget crisis reduced staffing to a 1:6 staff client ratio  
- Legislation just approved to increase to a 1:4 ratio | - Currently running at a 1:5  
- Need to hire 100 AC’s just to get to a 1:4—which is the minimum reg standards—not likely enough for AT | Out of Scope | The State of Washington must determine Rainier’s future function. As an ICF, many structural changes will need to be made to keep within the spirit of the federal ICF program. Recommend the state look at what other states have done with their outdated State Institutional model. Likely this will involve looking at the current model of Adult & Children services provided by private providers. It doesn’t appear that community providers (ICF/DD Waiver) are prepared to help the state with a transition out of institutions |
### Physical Environment
- Old institution in need of many repairs & updates
- Institution is isolated, with few community opportunities
- Meals are prepared in institutional kitchen & shipped to homes
- Few med rooms for SAM's privacy
- Not enough vehicles for daily community outings
- Many golf carts for pointless "rides" around the campus

### Outliers
- "The Wanderers" are an obvious gap in Active Treatment
- No discernable or meaningful skill acquisition occurs during these substantial periods of unsupervised time

### Out of Scope
- The State of Washington has to determine Rainier’s future function. As an ICF, many structural changes will need to be made to keep within the spirit of the federal ICF program. Recommend the state look at what other states have done with their outdated State Institutional model. Likely this will involve looking at the current model of Adult & Children services provided by private providers. It doesn’t appear that community providers (ICF/DD Waiver) are prepared to help the state with a transition out of institutions

### Corrective Action Not Initiated
- For those who benefit from the unsupervised excursions (assessment), wrap into IHP by Aug 15th
- For most of these wanderers, policy and practice must change to reduce the occurrence (PBSP—Elopement) by August 15th
<table>
<thead>
<tr>
<th>ATP/DP/REC</th>
<th>Exhibit B Rainier RCH</th>
</tr>
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<tbody>
<tr>
<td>• Program is only partially rolled out (after 10 months of implementation)</td>
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<td>• Program concentrates on ‘Classes” done in a classroom setting &amp; focuses on core needs (not prioritized needs)</td>
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<tr>
<td>• This program doesn’t focus on vocational or prevocational—at this point, it’s not a functioning piece of the ATS</td>
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<tr>
<td>Corrective Action Not Initiated</td>
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<tr>
<td>• ATP Director to develop an accurate timeline of rollout by June 29th.</td>
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<tr>
<td>• Whole program needs to be fully functioning by Aug 15 (complete with written programs)</td>
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<tr>
<th>Survey</th>
<th>Out of Scope</th>
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<tbody>
<tr>
<td>• In 2014, RCS was instructed by CMS that they were not surveying Active Treatment correctly. With CMS assistance, they corrected their practice</td>
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<td>• RCS notified the providers statewide of the changes and trained providers on Active Treatment (at Rainier Twice)</td>
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<tr>
<td>• Rainier PAT E did not adjust their programming or approach, or implement suggested RCS changes. In the meantime, new guidance came out that put them even further behind current Active Treatment understanding</td>
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<tr>
<td>• When PAT E was first taken out of Active Treatment, RCS observed very few corrections on PAT E with their follow-up survey.</td>
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<tr>
<td>Survey has changed and is now in accordance with CMS standard. These are basic standards every ICF must follow. Rainer (Central Office) must adjust to that change and to settle in to the Active Treatment ICF model</td>
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</table>
### ACTIVE TREATMENT

<table>
<thead>
<tr>
<th>Active Treatment Loop Stage</th>
<th>Current Process Issues</th>
<th>Status</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Functioning Assessment (CFA)</td>
<td>• Isn’t broad enough to address each end of the functioning spectrum, i.e. High functioning folks and folks functioning at a lower level, causing w 196, w197 issues&lt;br&gt;• HPA may not have all the current assessments from every discipline (ex: nursing assessment was from the previous year’s IDT in two of the three files reviewed and the Nursing Department had the most recent in their files, but it was not reflected in the current year’s IHP)&lt;br&gt;• The money management assessment completed by Attendant Counselor Manager (ACM’s) and Attendant Counselors (AC’s) is difficult to understand—individuals interviewed stated they didn’t understand how to fill it out and just guessed on the assessments they had been assigned to complete—also, assessment wasn’t broad enough to address higher functioning needs&lt;br&gt;• Assessments from different disciplines contradicted each other without being addressed in the Individual Habilitation Plan (IHP)&lt;br&gt;• If the CFA is not complete, the IHP is inaccurate</td>
<td>Correction Action Initiated</td>
<td>CFA to be updated to address the needs of each end of the functioning spectrum &amp; in to Q by each discipline by July 13th.</td>
</tr>
<tr>
<td>Interdisciplinary Treatment Team (IDT)</td>
<td>• No robust discussions b/ disciplines&lt;br&gt;• Meetings occurred without addressing discrepancies or challenging disciplines to work together to address specific obstacles that individual client faces to achieve their highest possible functioning level (ex: a self-administration of meds assessment indicated that medications refusals were common with an individual whose primary obstacle was her mental health and behavior. The Functional Behavior Assessment (FBA) mentioned her refusal of meds but did not address it as an objective with staff instructions on how to encourage compliance in a Positive Behavior Support Plan (PBSP). The result was a noted need from one discipline that was left unaddressed by the appropriate discipline</td>
<td>Correction Action Initiated</td>
<td>• All IDT Teams should review the CFA in total to assure each discipline’s addressed needs are addressed in the IHP by July 27th&lt;br&gt;• We completed an IDT meeting with an HPA on one of Fircrest’s “outliers” (high functioning individual whose IHP plan was failing to address her needs) as a training.&lt;br&gt;• Ongoing IDT training for all IDT members</td>
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<td>Exhibit C Fircrest RCH</td>
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<tr>
<td><strong>Individual Habilitation Plan (IHP)</strong></td>
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<td>• HPA’s observed (one was very new and the other just under a year) did not know how to run an IDT to facilitate discussion and problem-solving</td>
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<tr>
<td>• Based on an incomplete CFA &amp; IDT</td>
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<tr>
<td>• Content is not a mirror reflection of the individual</td>
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<tr>
<td>• W242 has been widely neglected</td>
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<td>Correction Action Initiated</td>
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<td>IHP’s will be updated by July 27th to include w242 needs (SAMS, meal prep &amp; Money mgt)</td>
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<tr>
<td><strong>Program Writing</strong></td>
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<tr>
<td>• Objectives are still not behaviorally stated with single measurable objectives</td>
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<td>• Staff instruction isn’t clear</td>
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<td>• Programming is not geared towards achieving highest individual functioning level</td>
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<tr>
<td>Correction Action Initiated</td>
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<tr>
<td>Programs re-written &amp; implemented (trained) on the floor by August 15th</td>
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<td><strong>Program Monitoring/Change</strong></td>
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<td>• When a goal is met or discontinued, HPA’s are not assuring another goal is prioritized to take its place</td>
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<td>• HPA’s are not analyzing data to seek out trends and addressing those in their monthly Q summaries</td>
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<td>• When the program isn’t working, instead of figuring out what’s wrong with the program, they dc it’s implementation without prioritizing another in its place</td>
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<tr>
<td>• No disciplines are running the programs they write on the floor to address implementation issues</td>
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<tr>
<td>Correction Action Initiated</td>
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<tr>
<td>• Q’s review monthly, based off data &amp; other discipline monthly summaries beginning for August summaries due in September</td>
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<tr>
<td>• Beginning immediately, disciplines will run their own programs on the floor to assess implementation issues</td>
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# FIRCREST ACTION PLAN

## OTHER ACTIVE TREATMENT CATEGORIES

<table>
<thead>
<tr>
<th>Category</th>
<th>Background</th>
<th>Current Process Issues</th>
<th>Status</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIDP</td>
<td>• HPA not functioning as full Q</td>
<td>• HPA’s are very new and are not confident or aware of their Q role</td>
<td>Corrective Action</td>
<td>• Initial Q reg training (Basic Surveyor Training—CMS), ongoing Q training, culture change at Fircrest and at Central Office regarding the Q position. Strengthen Q’s professional authority in policy and in practice. Change position back to QIDP from HPA.</td>
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<td>• Has had a lot of turnover with HPA’s and currently has many new HPA’s</td>
<td>• Established HPA’s are experiencing difficult adjustments in what they view as an expanding Q role (not a correction of a system that diminished the Q position in the first place)</td>
<td>Not Initiated</td>
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<td>• HPA’s not trained or relied on reg guidance</td>
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<td>Central Office</td>
<td>• Hires the Superintendent</td>
<td>• The current Superintendent does come with an ICF background and a strong working knowledge of the regs</td>
<td>Corrective Action</td>
<td>• In considering an applicant for a superintendent position, Central Office must assure that the individual has a working knowledge of ICF regulations</td>
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<td>DDA/DSHS</td>
<td>• Has had difficulty understanding Active Treatment</td>
<td>• She promotes leaders who also have working ICF reg knowledge</td>
<td>Not Initiated</td>
<td>• Central Office staff directing facility staff should also receive adequate training regarding Active Treatment and the regulations</td>
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<td>• In the past, hired Superintendents whose focus and experience was the SNF</td>
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<td>• and a medical model for the ICF soon followed</td>
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<td>• Typically allows the superintendent to run the program without much</td>
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<td>interference</td>
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<td>• Failed to recognize the Fircrest was no longer functioning as an ICF/ID (regulatorily speaking),</td>
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<td>Staffing</td>
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<td>• Fircrest was spared the staffing crisis Rainier faces and the Superintendent stated they have an overall 1:3 staff:client ratio</td>
<td>The State of Washington must determine Fircrest's future function. As an ICF, many structural changes will need to be made to keep within the spirit of the federal ICF program. Recommend the state look at what other states have done with their outdated State Institutional model. Likely this will involve looking at the current model of Adult &amp; Children services provided by private providers. It doesn't appear that community providers (ICF/DD Waiver) are prepared to help the state with a transition out of institutions.</td>
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<td>• Currently running at a 1:3—1:4 staff:client ratio</td>
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<td>• A Staff:client of 1:4 is the minimum reg standards – not likely enough for AT</td>
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<td>• Would strongly suggest that the Superintendent remain at a 1:3 staff:client ratio</td>
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<th>Physical Environment</th>
<th>Out of Scope</th>
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<td>• Institution is dated and in need of many repairs &amp; updates</td>
<td>The State of Washington must determine Fircrest's future function. As an ICF, many structural changes will need to be made to keep within the spirit of the federal ICF program. Recommend the state look at what other states have done with their outdated State Institutional model. Likely this will involve looking at the current model of Adult &amp; Children services provided by private providers. It doesn't appear that community providers (ICF/DD Waiver) are prepared to help the state with a transition out of institutions.</td>
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<td>• Although not isolated and is located within the broader community, individuals are not likely to access the community more than 1 time a week</td>
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<td>• Meals are prepared in institutional kitchen &amp; shipped to homes (PAT A's Director indicated that Dinner's were</td>
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<td>Exhibit C Fircrest RCH</td>
<td>current model of Adult &amp; Children services provided by private providers. It doesn’t appear that community providers (ICF/DD Waiver) are prepared to help the state with a transition out of institutions</td>
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| Outliers              | • Although the Active Treatment Loop is intact for many of Fircrest individuals, for the reasons stated above the individuals on the ends of the spectrum are not receiving active treatment  
• No discernable or meaningful skill acquisition occurs during these substantial periods of unsupervised time  
• There are a few ‘wanderers’ with free access to the campus and it is addressed in the IHP. Even though their free campus access was mentioned in the IHP, one of them had no active treatment in place throughout the day, he wandered the entire day spending time up at the main office or roaming the campus alone and was observed to be incontinent without staff intervention or awareness; the other is basically running the kitchen.  
• These outliers will be observed by the survey team and followed up on and will keep PAT A out on Active Treatment if it remains unaddressed |
| Corrective Action     | • Each IDT must identify the “outliers” and meet as a full IDT team to assure assessments are updated and address the needs of each of these individuals by July 30th  
• New programming addressing the newly assessed needs must be implemented with training by August 15th  
• The Active Treatment Schedules of these individuals must also be updated and reviewed by the Pat A Director and the Superintendent and implemented by Aug 15th |
| ATP/DP                | • Program is only partially rolled out  
• The AT program involving the work crews is successful and should be encouraged |
<p>| Corrective Action     | • Increase opportunity for involvement on work crews as much as possible |</p>
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<th>Current Superintendent</th>
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<td>• Been the Superintendent for 3 years and has instituted many changes attempting to correct the systems</td>
<td>• Megan is a strong leader and will implement what she feels is appropriate, making any of these current recommendations subject to her review and decision to implement</td>
<td>Corrective Action Not Initiated</td>
<td>• If the Superintendent has any questions or concerns about recommendations, we would welcome her to contact us for further robust discussion to address any of her concerns</td>
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<td>• She’s a strong leader whom is trusted by her staff</td>
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<td>• She has a good working knowledge of the ICF regulations</td>
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<td>• Selects the ‘right’ person for key positions</td>
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<td>• Megan reviews any suggested changes to systems or processes through regulation lenses and determines which ones may hurt or harm Fircrest. If she determines they will, that suggested change or process will not be implemented at Fircrest</td>
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<td>Exhibit C Fircrest RCH</td>
<td>• The vocational classroom setting for the others is more challenging. It appears that these areas (ATS) are understaffed and cannot meet the noted IHP goals within everyone’s IHP</td>
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<td>• Look for employment opportunity within the community</td>
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<td>• The Day Program functions as more of a retirement center with arts and crafts and other listed classes</td>
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<td>• Look to incorporate retirement activities within the community</td>
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<td>• Look to incorporate volunteering opportunities for individuals within the community</td>
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<td>• Whole program must to be fully functioning by Aug 15 (complete with written programs)</td>
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<td>• Program concentrates on work done in a classroom setting and work crews</td>
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<td>Survey</td>
<td>Out of Scope</td>
<td>Survey has changed and is now in accordance with CMS standard. These are basic standards every ICF must follow. Fircrest (Central Office) must adjust to that change and to settle in to the Active Treatment ICF model</td>
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<td>• In 2014, RCS was instructed by CMS that they were not surveying Active Treatment correctly. With CMS assistance, they corrected their practice.</td>
<td>• Outliers continue to remain unaddressed and continues to be a challenge to getting back into compliance with Active Treatment (literally one individual not receiving active treatment can take an entire facility out of Active Treatment).</td>
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<td>• RCS notified the providers statewide of the changes and trained providers on Active Treatment (at Fircrest once).</td>
<td>• Fircrest was not able to make the sudden changes and took the Active Treatment condition.</td>
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<td>• New guidance came out that put them even further behind current Active Treatment understanding.</td>
<td>• Fircrest PAT A improved upon many of their failed systems but failed to address the outliers.</td>
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<td>• Fircrest was not able to make the sudden changes and took the Active Treatment condition.</td>
<td>• Survey mentioned they saw the systems had been addressed for the great majority of folks, but that the outliers remain unaddressed.</td>
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Exhibit B
This report is the result of Complaint Investigation 3691354 at Rainier School PAT C. The investigation occurred on 02/03/20, 02/04/20, and 02/05/20. Failed provider practice was identified and an Immediate Jeopardy was called.

The survey was conducted by:
Linda Davis
Jim Tarr
Justin Smith
Gerald Heilinger

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

Telephone: 360-725-3215

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure there were enough Direct Care Staff (DCS) to provide for the supervision, protection, and care determined necessary by the facility assessments of nine of nine Sample Clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, and

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
RAINIER SCHOOL PAT C

#### Statement of Deficiencies

**W 104** Continued From page 1

1. **Review of Complaint Resolution Unit (CRU)**
   Intake 3691360, called in at 9:03 PM on 01/31/20 by the facility, showed that Client #1 was last seen around 6:00 PM that night.

   During an interview on 02/05/20 at approximately 3:00 PM, Staff A, Superintendent, stated that Client #1 had not been found.

2. Through record review and interviews, it was determined that the facility failed to deploy sufficient staff (enough DCS to effectively implement the active treatment programs as defined in the Individual Habilitation Plans (IHP) and Positive Behavior Support Plans (PBSP), to meet Client needs, and to respond to emergencies, illness, or injuries) to 2015 Quinault Court House to ensure that DCS could meet the assessed needs of all Clients at 2015 Quinault Court House.

   See W186 for details.

3. The facility did not ensure directions provided to DCS within IHPs and PBSPs would be achievable even when a DCS might be

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<td>WA40090</td>
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If continuation sheet Page 2 of 11
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>W 104</td>
<td>Continued From page 2 responsible for multiple Clients. The IHP and PBSP directions in one Client's case might prevent the DCS from being able to do both directions simultaneously.</td>
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<td>W 186</td>
<td>DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) 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 record review and interview, the facility failed to ensure there were enough Direct Care Staff (DCS) assigned to the house to meet the needs of nine of nine Sample Clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, and #9). The facility employed six DCS at 2015 Quinault Court House on swing shift, but they were not able to meet the need of knowing where Client #1 was, and Client #1 left the house. This failure resulted in Client #1 going missing and not being found. Findings included ... Review of the Rainier School Staff Communication Sheet for 2015 Quinault Court House, dated 01/31/20, showed the facility deployed six DCS to the house on the swing shift.</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX/ TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X5) COMPLETION DATE</td>
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<td>W 186</td>
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<td>W 186</td>
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<td>02/05/20</td>
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<td>Record review of Rainier School Duty Office Basic Care Levels sheet, dated &quot;revised 02/05/20&quot;, showed 2015 Quinault Court's PM shift minimum care level for staffing was six on the swing shift.</td>
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<td>Review of the Client Listing for 2015 Quinault Court House showed there were nine Clients living at the house.</td>
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<td>Review of the Rainier School Staff Communication Sheet for 2015 Quinault Court House, dated 01/31/20, showed, for swing shift, three DCS were assigned 1:1 supervision (dedicated to the care of that Client only) for one Client each (Client #2, #4, and #8). Two DCS were designated as &quot;Float&quot; staff and one staff was designated as the &quot;Charge&quot;. The two &quot;Float&quot; staff and the &quot;Charge&quot; staff had responsibility for the care of the remaining six Clients (Clients #1, #3, #5, #6, #7, and #9).</td>
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<td>During an interview on 02/05/20 at 12:44 PM, Staff B, Qualified Intellectual Disabilities Professional and Staff C, Developmental Disabilities Administrator 1, stated that DCS designated as &quot;Float&quot; were assigned to provide care for specific Clients who were not designated as 1:1 and to cover for staff breaks. They stated that staff designated as &quot;Charge&quot; were not assigned specific Clients to care for but provided coverage for breaks and helped with Clients where needed. The result of this was that during break coverage times there would be only two staff caring for the six Clients not designated as 1:1.</td>
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<td>Record review of the Staff Communication Sheet, dated 01/31/2019, from 1800 to 1930 (the time</td>
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Continued From page 4 when Client #1 may have left the house showed:
- From 1800 - 1830, Staff K was on lunch break, leaving two staff to care for the six Clients not designated as 1:1.
- From 1830 - 1900, Staff G was on lunch break, leaving two staff to care for the six Clients not designated as 1:1.
- From 1900 - 1930, Staff F and Staff H were on lunch break leaving one staff to care for the six Clients not designated as 1:1.

The needs of the six Clients (Clients #1, #3, #5, #6, #7, and #9) who were not 1:1 were significant and would, at any given time, require a DCS to provide their undivided attention for a time leaving them unable to meet needs of any of the other five Clients).

Clients #5, #6, and #9 required direct staff intervention for their basic care, safety, and transferring in/out of wheelchairs.

Clients #1, #3, and #7 had physical aggression requiring staff to protect other Clients from their behavior.

Clients #1 required staff to follow him when he left the house.

Client #3 required staff to follow him, if they were available, but to locate him if he was gone from the house over 15 minutes.

The following specific needs, of the six Clients who were not assigned 1:1 DCS, would require undivided attention of staff for a given period of time, were:
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<td>W 186</td>
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<td>Record review of Client #1’s Individual Habilitation Plan (IHP), dated 08/06/19, and Positive Behavior Support Plan (PBSP), dated 08/06/2019, showed:</td>
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<td>- He required 1:1 supervision whenever he left his house. This supervision required Staff to have Client #1 within their line of sight.</td>
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<td>- Staff were required to be in a position to get in between Client #1 and any peer he was aggression towards.</td>
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<td>- Client #1’s supervision would be upgraded to include 1:1 line of sight supervision on his house, for 24 hours, if he was physically restrained due to aggression or attempted elopements.</td>
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<td>- Client #1’s challenging behaviors include verbal aggression, physical aggression, elopement, and inappropriate sexual behavior.</td>
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<td>- Client #1’s challenging behaviors escalate after family visits and when he makes frequent phone calls.</td>
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<td>Record review of Client #3’s IHP, dated 10/24/19, and PBSP, dated 11/29/19, showed:</td>
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<td>- He required 1:1 line of sight supervision, from 0600 to 1400 daily.</td>
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<td>- Staff must accompany Client #3 to the coffee shop, vending machines and off campus.</td>
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<td>- When Client #3 left the house, staff should shadow Client #3 if one is available. If staff is not available they still must locate Client #3 after he’s been off the house for 15 minutes. If Client #3 cannot be located in 30 minutes, Staff will following Missing Client policy.</td>
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<td>- Client #3’s challenging behaviors include physical aggression, property destruction and inappropriate acquisition.</td>
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<td>- Immediate intervention is required for aggression towards himself, aggression towards others, inappropriate acquisition, and property destruction.</td>
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Record review of Client #5's IHP, dated 08/01/19 and PBSP, dated 08/01/19, showed:

- He is dependent on a wheelchair for mobility on and off house.
- Client #5 needs a staff when going off campus.
- Client #5 needs staff assistance when transferring out of his wheelchair.
- Client #5's challenging behaviors include verbal aggression.

Record review of Client #6's IHP, dated 07/09/2019, showed:

- He uses a wheelchair for optimal mobility.
- Client #6 requires physical assistance for transfers in and out of his wheelchair.
- Client #6 requires physical assistance with toileting, showering/bathing, and dressing.

Record review of Client #7's IHP, dated 05/14/19, and PBSP, dated 05/14/19, showed:

- He has no special supervisory requirements
- Client #7's challenging behaviors include swearing and physical aggression.
- Client #7's interventions include protecting peers from him and using Therapeutic Options (methods for protecting Clients and reducing aggressive behaviors).

Record review of Client #9's IHP, dated 10/09/19, showed:

- He requires staff supervision when in the community due to inability to recognize hazards.
- Client #9 requires verbal assistance when toileting, showering/bathing, and dental hygiene.
- Client #9 requires physical assistance in adjusting water temperatures, brushing his teeth, dressing, shaving, serving food, and his personal...
During DCS meal breaks (30 minutes for each of the six DCS assigned to the house on swing shift, a total time period involving 3 hours if only one staff at a time went on break), the needs of the six Clients not assigned 1:1 staff would need to be taken care of by two staff.

During DCS 15 minute breaks (15 minutes for each of the six DCS assigned to the house on swing shift, a total time period involving 1 hour and 30 minutes if only one staff at time went on break), the needs of the six Clients not assigned 1:1 staff would need to be taken care of by two staff. (This scenario would occur two times during each shift as DCS are allotted two 15 minute breaks per shift.)

Some examples of the risks to the six Clients (Clients #1, #3, #5, #6, #7, and #9) not assigned 1:1 staff could include, but not limited to:

1. During a time of staff breaks where two DCS would be providing the care for the six Clients, one staff might be assisting Client #6 in the bathroom while the second staff might have left the house with Client #1 leaving Client #3 able to leave the house without a staff being aware, be aggressive to one of the other three Clients, steal property, or destroy property without a DCS to intervene.

2. During a time of staff breaks where two DCS would be providing the care for the six Clients, Client #3 leaves the house and one of the staff follows him. A few minutes later, Client #1 leaves the house. The remaining staff now faces a
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<th>ID (X5)</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 186</td>
<td></td>
<td></td>
<td>Continued From page 8 decision of whether to follow Client #1 leaving the remaining four Clients unsupervised or not follow Client #1 and supervise the remaining four Clients.</td>
<td>W 186</td>
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<tr>
<td>W 234</td>
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<td>3. During a time of staff breaks where two DCS would be providing the care for the six Clients, Client #9 decides to take a shower which would require one of the staff to assist with regulating the water temperature and then provide verbal assistance for the shower. Client #6 needs to use the toilet requiring the second staff to assist him. No staff would be available to know if Clients #1 and #3 left the house.</td>
<td>W 234</td>
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</tbody>
</table>

**INDIVIDUAL PROGRAM PLAN**

CFR(s): 483.440(c)(5)(i)

Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure directions provided to Direct Care Staff (DCS) within Individual Habilitation Plans (IHP) and Positive Behavior Support Plans (PBSP) would be implemented as written for nine of nine Sample Clients (Clients #1, #2, #3, #4, #5, #6, #7, #8, and #9) when a DCS was responsible for multiple Clients. DCS at 2015 Quinault Court House on swing shift did not have up to date instructions for duties related to their assignments. This failure resulted in Client #1 going missing and not being found.

Findings included ...

Review on 02/03/20 of the Swing Shift Post Book
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
50G047

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
C
02/05/2020

NAME OF PROVIDER OR SUPPLIER
RAINIER SCHOOL PAT C

STREET ADDRESS, CITY, STATE, ZIP CODE
RYAN ROAD
BUCKLEY, WA 98321

(X4) ID PREFIX TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X5) ID PREFIX TAG
PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)

(W 234) Continued From page 9

Continued From page 9

for 2015 Quinault Court House showed directions to staff on what to do for each post (the assignment for each staff related to Clients to supervise and other duties). It did not contain directions specifically related to Client #1. It contained directions to staff related to Clients who no longer resided at 2015 Quinault Court House.

During an interview on 02/04/20 at 1:32 PM, Staff D, Attendant Counselor Manager, stated that the Swing Shift Post book had not been updated since September, 2019.

During an interview on 02/07/20 at 8:10 AM, Staff B, QIDP, stated that she believed Client #1 moved to 2015 Quinault Court House on 10/11/19.

During an interview on 02/03/20, Staff E, Attendant Counselor 2 (Shift Charge that day), stated that the Post Book was being updated and that shift charges verbally directed DCS on their duties. She indicated that the "Float" positions should be aware of Client #1's whereabouts when he was at the house.

Review of the Swing Shift Post Book for 2015 Quinault Court House showed the following general direction for the two Float posts: "FOLLOW ALL PBSPS ..."

Review of Client #1's PBSP, dated 08/06/19, showed that Client #1 was "...provide with protective supervision off of the house." It also stated that during the protective supervision, staff were to keep Client #1 in their line of sight. These directions indicated that if Client #1 left the house, a staff needed to leave the house and follow him.

W 234
<table>
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<th>ID</th>
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<tbody>
<tr>
<td>W 234</td>
<td>Continued From page 10</td>
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<tr>
<td></td>
<td>Record review of Client #1's IHP, dated 08/06/19, and PBSP, dated 08/06/2019, showed it did not have instructions or directions provided to staff on how staff should monitor Client #1 while at the house to ensure they knew when he left the house, while also providing care for other Clients.</td>
<td></td>
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<tr>
<td></td>
<td>Review of CRU Intake 3691360 showed staff were not aware Client #1 had left the house and so did not follow him.</td>
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</tbody>
</table>
Exhibit C
This report is the result of complaint investigation #3730168 at Rainier School, Program Area Team C, investigated onsite on 09/21/20 and 09/25/20, and offsite on 09/22/20, 09/23/20, 09/24/20, 10/01/20, 10/06/20, 10/07/20, 10/08/20 and 10/23/20 due to the ongoing COVID-19 pandemic. Deficient practice was identified and an Immediate Jeopardy level citation was cited, along with standard level citations.

This 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
PO Box 45600, MS: 45600
Olympia, WA 98504
Telephone: (360) 725-3215

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to provide the number of staff they determined was sufficient to provide the care and supervision of Clients at one of eight houses (1040 Quinault Court [QC]), and did not identify...
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>Multiple Construction Location</th>
<th>Provider/Supplier/CLIA Identification Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. WING _____________________________</td>
<td>50G047</td>
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</tbody>
</table>

**State of Washington**

**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Form CMS-2567(02-99) Previous Versions Obsolete**

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**Name of Provider or Supplier:** Rainier School Pat C

**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

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<table>
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<th>ID Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>W 104</td>
<td>Continued From page 1 when the house was working under their identified basic staffing level. Client #1 left his residence (1040 QC) twice in one day when there was not the assigned number of staff at the house, and again two days later when staffing was below their basic staffing level. This failure placed Client #1 at risk for injury, and prevented the facility from acting on the lack of sufficient staffing levels, putting all the Clients at 1040 QC at risk for not having their needs met. Findings included ...</td>
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</tr>
<tr>
<td>W 104</td>
<td>Record review of Complaint Resolution Unit (CRU) Intake # 3730168 showed Client #1 left the facility campus on 09/17/20. During an interview with Client #1 on 09/21/20 at 11:01 AM, the State surveyor asked Client #1 where he was headed when he left the house. Client #1 responded, &quot;To Snohomish County.&quot; Review of the facility's initial investigation report (IR) #9366, dated 09/17/20, showed Client #1 left the campus without telling staff. The facility Behavior Response Team (BRT) - a group of staff trained to respond when Clients exhibit behaviors that could harm themselves or others) was called and brought Client #1 back to campus on 09/17/20 around 2:45 PM. The incident report showed that staff called the facility BRT because 1040 QC only had two staff and could not follow Client #1 when he left the campus at 2:20 PM. The facility BRT returned Client #1 to 1040 QC around 2:45 PM. Record review of the facility 5-Day Investigation Report for IR #9366, dated 09/17/20, showed</td>
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**Event ID**: HGR311  
**Facility ID**: WA40090
**Summary Statement of Deficiencies**

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<td>W 104</td>
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Continued From page 2

Four staff assigned to 1040 QC for the AM shift and only three staff for the PM shift. The IR stated that Client #1 left during shift change and three staff were actually at the house when Client #1 left, not two staff as the initial IR reported. The IR concluded that the lack of staff at the house contributed to Client #1 leaving the campus, as the staff at 1040 QC could not respond to Client #1 when he left the campus.

During an interview on 09/25/20 at 12:19 PM, Staff C, Office Support Supervisor, stated that the facility BRT responded to two calls for Client #1 on 09/17/20, once at 2:24 PM, and again at 9:40 PM.

Review of Client #1’s file showed an Individual Habilitation Plan (IHP), dated 08/05/20, which identified an alert for staff, “[Client #1’s first name] is unaware of his own safety, limited safety awareness inside the home and in the community. He is unaware of traffic safety ...” and Client #1’s behavioral challenges included aggression and elopement. Client #1’s Positive Behavior Support Plan (PBSP), signed 09/01/20, showed elopement as a challenging behavior to decrease. It showed that elopement was a potential life-threatening situation due to his lack of traffic safety, and showed, “Once his mind is set on leaving, he is difficult to redirect and his persistence to leave can lead to dangerous situations. He may elope because he wants to return to the safety of his past life ...”

During an interview on 09/21/20 at 12:22 PM, Staff J, Attendant Counselor Manager (ACM), stated that the basic staffing levels at 1040 QC on both the AM and PM shift was six staff.
During an interview on 09/29/20 at 11:40 AM, Staff J stated that the basic staffing level at 1040 QC was three staff for the overnight shift.

Record review of an untitled/undated document, provided by the facility Duty Office (the office that is responsible for assigning where staff were to work) on 09/25/20, showed the facility’s definition of their basic staffing level, their critical staffing level, and their emergent staffing levels for all houses on campus. The staffing levels for 1040 QC were as follows:

- Basic staffing was seven staff for the AM (6:00-2:30) and PM (2:00-10:30) shifts
- Critical staffing was four staff for the AM and PM shifts
- Emergent staffing was two staff for the AM and PM shifts
- Basic staffing was three staff for the night shift (10:00 PM-6:30 AM)
- Critical staffing was two staff for the night shift

Record review of 1040 QC Staff Communication Sheet, dated 09/17/20, showed three staff (one of the three was Staff G, Attendant Counselor (AC), who was also on the AM shift) assigned to work the PM shift with eight Clients. Staff documented that Client #1 left the house again at 9:35 PM and returned at 10:05 PM. It did not indicate if Client #1 came back on his own or if staff assisted him back to 1040 QC.

During an interview on 09/25/20 at 12:19 PM, Staff C, Office Support Supervisor, stated that the facility and local law enforcement responded at
Continued From page 4
9:40 PM to the public street in front of the facility because Client #1 left the campus without staff.

During an interview on 09/21/20 at 11:26 AM, Staff G stated that her shift was 10 hour days, four days a week from 8:00 AM to 6:30 PM.

Record review of an email from the facility Human Resources office, dated 09/30/20, showed Staff G completed her shift on 09/17/20 at 6:30 PM, leaving only two staff assigned to 1040 QC from 6:30 PM until the night shift arrived at 10:00 PM.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware that only two staff worked at 1040 QC on the PM shift on 09/17/20.

Record review of 1040 QC Staff Communication Sheet, dated 09/18/20, showed staff documented "only 2 staff basic care" at 8:55 AM when a staff went off duty, leaving only two staff to care for eight Clients, which included Client #1. At 10:50 AM, another staff arrived at 1040 QC, bringing two additional Clients that were staying in the facility isolation (COVID-19) house and were able to return to their prior living arrangement at 1040 QC.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware that only two staff worked at 1040 QC for part of the AM shift on 09/18/20.

Record review of 1040 QC Staff Communication Sheet, dated 09/18/20, showed staff documented "only 2 staff basic care" at 8:55 AM when a staff went off duty, leaving only two staff to care for eight Clients, which included Client #1. At 10:50 AM, another staff arrived at 1040 QC, bringing two additional Clients that were staying in the facility isolation (COVID-19) house and were able to return to their prior living arrangement at 1040 QC.
W 104  
Continued From page 5
Sheet, dated 09/19/20, showed three staff assigned to the AM shift to provide care and supervision for 10 Clients, which included Client #1. Staff documented that Client #1 left his house alone at 7:55 AM and they called a house at the opposite end of the campus to bring Client #1 back. If that house were unable to escort Client #1 back to 1040 QC, they would call the facility BRT to bring him back.

During an interview on 10/08/20 at 9:29 AM, Staff A stated that she had not been notified of 1040 QC staffing levels on 09/17/20-09/20/20.

2. Record review of an untitled/undated document, provided by the facility Duty Office (the office that is responsible for assigning where staff were to work) on 09/25/20, showed the facility's definition of their basic staffing level, their critical staffing level, and their emergent staffing levels for all houses on campus. The staffing levels for 1040 QC were as follows:

- Basic staffing was seven staff for the AM and PM shifts
- Critical staffing was four staff for the AM and PM shifts
- Emergent staffing was two staff for the AM and PM shift
- Basic staffing was three staff for the overnight shift
- Critical staffing for the overnight shift was two staff

Staffing on Thursday 09/17/20
Record review of Rainier School Staff Communication Sheet for 1040 QC, dated
W 104 Continued From page 6
09/17/20, showed:

- Four staff assigned to 1040 QC for the AM shift, which showed the house had critical staffing.
- Three staff assigned to the PM shift, including Staff G, AC. Staff G’s shift ended at 6:30 PM, which put staffing at the house into the emergent level.
- Two staff assigned to the overnight shift, which showed the house had critical staffing.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware of the emergent staffing levels at 1040 QC on 09/17/20.

Staffing on Friday 09/18/20
Record review of Rainier School Staff Communication sheet for 1040 QC, dated 09/18/20, showed:

- Five different staff names written on three different post assignments for the AM shift. At any given time, only three staff were actually at the house at one time from 6:00 AM to 8:55 AM. Staff documented that at 8:55 AM, Staff H, AC, went off duty, leaving only two staff, which put the house at an emergent staffing level. Then at 10:50 AM, Staff I, AC, arrived at the house with two additional Clients that were returning from the facility isolation house; one of which required 1:1 staffing (staff assigned to remain within arm’s reach of the Client) and the other Client required staff to keep him within staff line of sight. The arrival of Staff I with two additional Clients brought the house census to 10 Clients. The arrival of Staff I took the house out of emergent level.
Continued From page 7

staffing, however the two additional Clients significantly increased the supervision requirements from staff and still left the house at critical staffing levels;

-Five staff assigned to the PM shift, one of which was Staff G. The communication sheet showed she left at 5:00 PM, leaving four staff at 1040 QC, which put the house in critical staffing; and

-Two staff assigned to the overnight shift, which showed the house had critical staffing. Staff documented a fire alarm (not a planned fire drill) occurred at 3:52 AM and the Clients at the house had to be evacuated.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware of the critical staffing levels at 1040 QC on 09/18/20.

Staffing on Saturday 09/19/20

Record review of Rainier School Staff Communication sheet for 1040 QC, dated 09/19/20, showed:

-Three staff on the AM shift, which put the house between critical and emergent staffing levels. At 7:55 AM, Client #1 left the house and the staff at 1040 QC had to rely on staff from another house at the opposite end of the campus to bring him back.

-Four staff on the PM shift, which put the house in critical staffing.

-Two staff on the overnight shift, which put the
W 104
Continued From page 8
house in critical staffing.

During an interview on 10/08/20 at 9:29 AM, Staff A stated that she was not notified of staffing concerns from 09/17/20-09/20/20.

Staffing on Sunday 09/20/20
Record review of Rainier School Staff Communication sheet for 1040 QC, dated 09/20/20, showed:

-Three staff on the AM shift, which put the house between critical and emergent staffing.

-Three staff on the PM shift, which put the house between critical and emergent staffing.

During an interview on 09/25/20 at 11:24 AM, Staff D, Duty Officer, stated that when only two staff worked at 1040 QC, it resulted in an emergent staffing situation and the Superintendent would be notified. Staff D stated that the facility had been in emergent staffing situations on weekends. The Duty Office would shuffle staff from other houses or attempt to fill the open positions with on call staff, or attempt to get a house manager to come in at the time the house was identified as having less than the basic number of staff.

During an interview on 09/25/20 at 11:46 AM, Staff A stated that all houses had at least one Adult Training Program (ATP) staff that worked Monday-Friday and their name should be on the Communication Sheet. When asked to identify the ATP staff assigned to 1040 QC, Staff A phoned the ATP supervisor. Staff A stated that the assigned ATP staff had been off work for at...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID 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 104         | Continued From page 9  
least two weeks and no ATP staff replaced her at 1040 QC. Staff A stated that she should have been notified of emergent staffing levels.  
During an interview on 10/08/20 at 9:29 AM, Staff A stated that she was not notified of staffing concerns 09/17/20-09/20/20. | W 104        |                                                                                                  |                 |
| W 122         | CLIENT PROTECTIONS  
CFR(s): 483.420  
The facility must ensure that specific client protections requirements are met.  
This CONDITION is not met as evidenced by:  
Based on record review and interview, the facility failed to correct their staffing process to ensure enough staff were available to meet the health and safety needs of one of one Sample Clients (Client #1), when he left the campus on three occasions when his residence had less than the required number of staff working. This failure put Client #1 at risk for injury, up to and including death, and all Clients residing at 1040 Quinault Court (QC) at risk for not having their needs met.  
Findings included ...  
Review of the Washington State ASPEN system (an automated survey process where surveyors document deficient practice in the form of written citations) showed the facility received four citations related to insufficient staffing in five months. The facility has not corrected the identified deficient practice as of the writing of this citation. | W 122        |                                                                                                  |                 |
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** RAINIER SCHOOL PAT C  
**Street Address, City, State, Zip Code:** RYAN ROAD, BUCKLEY, WA 98321  
**Provider's Plan of Correction**

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<td>W 122</td>
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#### a. Investigation of Complaint Resolution Unit

Intake #3691354 resulted in an Immediate Jeopardy citation on 02/05/20 when a Client left campus and was not found. The Client was still missing as of this citation; see ASPEN ID D9ZU11 for details.

#### b. The facility did not remove the immediate risk of harm to Clients on 02/28/20; see ASPEN ID D9ZU12 for details.

#### c. A revisit on 07/27/20 showed ongoing noncompliance; see ASPEN ID D9ZU13 for details.

#### d. Investigation of CRU intake #3709563 resulted in citation on 07/31/20; see ASPEN ID 6RL711 for details.

Record review of Complaint Resolution Unit (CRU) Intake #3730168 showed Client #1 left the facility campus on 09/17/20.

During an interview on 09/21/20 at 12:22 PM, Staff J, Attendant Counselor Manager (ACM), stated that six staff should be assigned to work at 1040 QC on both the AM and PM shifts.

Review of Rainier School Staff Communication Sheets, dated 09/17/20, showed three staff assigned to 1040 QC (where Client #1 resided) on the PM shift. Staff documented that the facility Behavioral Response Team (BRT- a group of staff trained to respond when Clients exhibit behaviors that could harm themselves or others) was called to the public road in front of the campus for Client #1 around 2:10 PM. Client #1 left his residence again at 9:35 PM.

During an interview on 09/25/20 at 12:19 PM,
<table>
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<th>ID</th>
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<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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</table>
| W122 | | | Continued From page 11
Staff C, Office Support Supervisor, stated that the facility BRT responded to two calls for Client #1 on 09/17/20, once at 2:24 PM, and again at 9:40 PM with local law enforcement also on site.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware that only two staff worked at 1040 QC on the PM shift on 09/17/20.

Record review of 1040 QC Staff Communication Sheet, dated 09/18/20, showed staff documented "only 2 staff basic care" at 8:55 AM when a staff went off duty, leaving only two staff to care for eight Clients, which included Client #1.

During an interview on 09/25/20 at 11:46 AM, Staff A, Superintendent, and Staff B, Assistant Superintendent, stated that they were not aware that only two staff worked at 1040 QC for part of the AM shift on 09/18/20.

Record review of 1040 QC Staff Communication Sheet, dated 09/19/20, showed three staff assigned to the AM shift to provide care and supervision for 10 Clients, which included Client #1. Staff documented that Client #1 left his house alone at 7:55 AM and they called a house at the opposite end of the campus to bring Client #1 back. If that house were unable to escort Client #1 back to 1040 QC, they would call the facility BRT to bring him back.

During an interview on 10/08/20 at 9:29 AM, Staff A stated that she had not been notified of 1040 QC staffing levels on 09/17/20-09/20/20. | W122 | | | | | | |
| W186 | | | DIRECT CARE STAFF | W186 | | | | |
## Summary Statement of Deficiencies

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 record review and interview, the facility failed to ensure they provided the required number of Direct Care Staff (DCS) to provide the identified care and supervision for one of ten Sample Clients (Client #1) and three Expanded Sample Clients (Client #2, Client #3, and Client #4) residing at 1040 Quinault Court (QC). Client #1 left the campus alone twice in one day and required additional staff, plus Local Law Enforcement, to accompany him back safely. Client #2 did not have staff assigned to provide his required supervision. Client #3 was at risk for leaving his house unsupervised, and Client #4 did not have a staff assigned to provide care and supervision of only him. These failures placed all Clients at 1040 QC at risk for injury and for not having their basic care needs met.

Findings included ...

During an interview on 09/21/20 at 12:22 PM, Staff J, Attendant Counselor Manager (ACM), stated that the basic staffing levels for 1040 QC for both the AM and PM shift was six staff.
Client #1
Record review of Rainier School Incident Report # 9366, dated 09/17/20, showed Client #1 told staff he was going to visit another house on campus at 2:20 PM. DCS phoned the house. Client #1 said he was going to visit. DCS phoned the facility Behavior Response Team (BRT—a group of staff trained to respond when Clients exhibit behaviors that could harm themselves or others) because 1040 QC only had three staff at the house at the time, so they could not follow Client #1 when he left the campus.

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/17/20, showed four staff assigned to the AM shift to provide care and supervision for eight Clients, including Client #1.

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/17/20, showed three staff assigned to provide care and supervision for eight Clients, including Client #1, at 1040 QC for the PM shift. At 2:10 PM, the facility BRT responded to the public road in front of the campus for Client #1 because he left the campus without staff. Client #1 left the house again at 9:35 PM and returned to the house at 10:05 PM. It did not indicate if Client #1 returned at 10:05 PM alone or if staff assisted him back to 1040 QC.

Record review of Client #3's Active Treatment Progress Notes, dated 09/17/20 at 2:20 PM, showed two staff were required to redirect Client #3 from leaving 1040 QC three times in the same time span that Client #1 left the house on 09/17/20.
Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/18/20, showed five different names listed in three different post assignments for the AM shift to provide care and supervision for eight Clients, including Client #1. At any given time only three DCS were at the house until 8:55 AM when one DCS left, leaving two DCS to care for eight Clients. At 10:55 AM, Staff I, Attendant Counselor, arrived with Client #2 and Client #3 (released from the facility COVID-19 isolation house and cleared to return to their prior residence.) The arrival of Staff I brought the staffing level to three DCS; however, the two Clients that returned required a significant amount of staff supervision.

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/18/20, showed Staff G left at 5:00 PM, leaving four staff to care for 10 Clients, including Client #1.

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/19/20, showed three staff assigned to the house for the AM shift to provide care and supervision for 10 Clients, including Client #1. Staff documented that Client #1 left his house alone at 7:55 AM and DCS at 1040 QC called a house at the opposite end of the campus to bring Client #1 back. If staff at that house were unable to escort Client #1 back to 1040 QC, they stated that they would call the facility BRT to bring him back to 1040 QC.

Record review of the Rainier School Staff
<table>
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<tr>
<th>ID</th>
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<td>W 186</td>
<td>Continued From page 15</td>
<td></td>
<td>Communication Sheet for 1040 QC, dated 09/19/20, showed four staff assigned to the house for the PM shift to provide care and supervision for 10 Clients, including Client #1.</td>
<td>W 186</td>
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</table>

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/20/20, showed three staff assigned to the house for the AM shift to provide care and supervision for 10 Clients, including Client #1.

Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/20/20, showed three staff assigned to the house for the PM shift to provide care and supervision for 10 Clients, including Client #1.

Review of 1040 QC post assignments (a facility document that describes which Clients staff are assigned to care for during their shift) showed Client #1 was one of three Clients assigned to Post #5. If the house had only three staff, then Client #1 would move to Post #4. Post #4 listed one Client, Client #3. Client #3 required staff to remain within 5 feet of him whenever he was out of his bedroom, whether he was in the house, anywhere on campus, or off campus. Client #3 had a history of elopement and had alarms on his bedroom door and bedroom window to alert staff if he left the house so they could follow him quickly. Post #4 assignment also showed that when the house had only three staff, Post #4 would then become Post #3 and would include: Client #1, Client #3, Client #5, Client #6, Client #7, and Client #8 (Client #8 was in the [redacted] during the dates reviewed).

On six of the seven dates listed above when...
**W 186** Continued From page 16

there were only three staff at 1040 QC, DCS were responsible for providing the following care and supervision of the Clients, as assigned by the facility, based on review of the facility documents.

One staff assigned to Post #3

-Client #1's file showed an Individual Habilitation Plan (IHP), dated 08/05/20, which identified an alert for staff, "[Client #1's first name] is unaware of his own safety, limited safety awareness inside the home and in the community. He is unaware of traffic safety ..." and Client #1's behavioral challenges included aggression and elopement. Client #1's Positive Behavior Support Plan (PBSP), signed 09/01/20, showed elopement as a challenging behavior to decrease. It showed that elopement was a potential life-threatening situation due to his lack of traffic safety, and that "Once his mind is set on leaving, he is difficult to redirect and his persistence to leave can lead to dangerous situations. He may elope because he wants to return to the safety of his past life ..."

-Client #3's IHP, dated 01/15/20, showed Client #3 required staff to remain within 5 feet of him during both the AM and PM shift, unless he was in his room with the alarms activated. When Client #3 left his room, staff were to provide dedicated supervision only to him because he did not appear to be aware of environmental, community or traffic hazards. Client #3 had eloped from his prior home, had evaded staff supervision, and would exhibit self-injurious behavior (SIB). Staff should respond quickly if he left the residence due to his lack of safety awareness.

<table>
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<tr>
<th>ID</th>
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</table>
| W 186 | | Continued From page 16 there were only three staff at 1040 QC, DCS were responsible for providing the following care and supervision of the Clients, as assigned by the facility, based on review of the facility documents.

One staff assigned to Post #3

-Client #1's file showed an Individual Habilitation Plan (IHP), dated 08/05/20, which identified an alert for staff, "[Client #1's first name] is unaware of his own safety, limited safety awareness inside the home and in the community. He is unaware of traffic safety ..." and Client #1's behavioral challenges included aggression and elopement. Client #1's Positive Behavior Support Plan (PBSP), signed 09/01/20, showed elopement as a challenging behavior to decrease. It showed that elopement was a potential life-threatening situation due to his lack of traffic safety, and that "Once his mind is set on leaving, he is difficult to redirect and his persistence to leave can lead to dangerous situations. He may elope because he wants to return to the safety of his past life ..."

-Client #3's IHP, dated 01/15/20, showed Client #3 required staff to remain within 5 feet of him during both the AM and PM shift, unless he was in his room with the alarms activated. When Client #3 left his room, staff were to provide dedicated supervision only to him because he did not appear to be aware of environmental, community or traffic hazards. Client #3 had eloped from his prior home, had evaded staff supervision, and would exhibit self-injurious behavior (SIB). Staff should respond quickly if he left the residence due to his lack of safety awareness. |
W 186 Continued From page 17
-Client #5’s IHP, dated 07/22/20, showed she required Protective Supervision (PRO) line of sight (LOS - Staff were to keep her within line of sight and go wherever she went) when she engaged in physical aggression toward others, destroyed property in a manner that put herself or others’ safety at risk, or left the campus unsupervised. Client #5 also had a door alarm activated at night and a window alarm activated at all times to alert staff of her leaving.

-Client #6’s IHP, dated 04/22/20 showed he exhibited the following: Verbal Aggression: Defined as yelling at others or making threats to harm others. Physical Aggression: Defined as physically striking others. Disruptive Behavior: Defined as striking a hard surface with his body parts, tipping over or throwing furniture and repeated door slamming. Inappropriate Toileting: Defined as urinating or defecating somewhere other than the toilet. Non-Reality, Behavior: Defined as thinking someone poisoned his food, people were trying to kill him, or saying ghosts were out to get him and he would try to walk through walls.

-Client #7’s file showed a PBSP, signed 09/15/20, that identified physical aggression as a behavior needing to decrease. Client #7 would grab, hit, scratch, or strike out at anyone near him. Client #7's IHP, dated 06/22/20, showed he had decreased vision, used a wheelchair for mobility (due to his poor balance and his ability to walk being severely impaired), and required assistance to transfer and to use the bathroom.

During an interview on 10/07/20 at 9:57 AM, Staff J, ACM, Staff K, Qualified Intellectual Disability
Professional (QIDP), and Staff L, Developmental Disabilities Administrator 2 (DDA2), was asked how three staff would provide the care and supervision needs of the assigned Clients, they stated that with only three staff working the staff would have to share the responsibility of all the Clients at the house. That would include staff prioritizing Client needs and potentially having to supervise more than one Client at a time, even if the Client required a 1:1 staff (one staff assigned to care for only one Client) and staff would need to rely on the facility BRT to assist with any Client behaviors.

Client #3
Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/19/20, showed four staff assigned to the PM shift. The sheet showed Staff N, AC, assigned to kitchen duties, Client #3, Client #7, and Client #10.

-Client #3’s IHP, dated 01/15/20, showed Client #3 required staff to remain within 5 feet of him during both the AM and PM shift, unless he was in his room with alarms activated. When Client #3 left his room, staff were to provide dedicated supervision because he did not appear to be aware of environmental, community or traffic hazards. Client #3 had a history of elopement from his prior home, would evade staff supervision, and would exhibit self-injurious behavior (SIB).

-Client #7’s file showed a PBSP, signed 09/15/20, that identified physical aggression as a behavior needing to decrease. Client #7 would grab, hit, scratch, or strike out at anyone near...
### Summary Statement of Deficiencies

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| W186 | Continued From page 19 | | him. Client #7's IHP, dated 06/22/20, showed he had decreased vision, used a wheelchair for mobility (due to his poor balance and his ability to walk being severely impaired), and required assistance to transfer and to use the bathroom.  
-Client #10's PBSP, signed 12/16/20, showed she would hoard items that were not hers, made verbal threats, and would exhibit physical aggression towards others. The PBSP instructed staff to "Regularly, try to give her your undivided attention."  
During an interview on 10/07/20 at 9:57 AM, Staff J, ACM, Staff K, Qualified Intellectual Disability Professional (QIDP), and Staff L, Developmental Disabilities Administrator 2 (DDA2), was asked how three staff would provide the care and supervision needs of the assigned Clients, they stated that with only three staff working the staff would have to share the responsibility of all the Clients at the house. That would include staff prioritizing Client needs and potentially having to supervise more than one Client at a time, even if the Client required a 1:1 staff (one staff assigned to care for only one Client) and staff would need to rely on the facility BRT to assist with any Client behaviors.  
One staff assigned to Post #1 (3 staff working) Record review of post assignment #1 for 1040 QC showed one staff assigned to provide care and supervision to only one Client, Client #4. He required staff to keep him within their line of sight, especially around in the kitchen, as he would touch/drink hot items, and he was very compulsive with limited safety awareness. When only three staff were working at 1040 QC, they... |
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<td>W 186</td>
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<td>Continued From page 20 would assume responsibility for providing the care and supervision of Client #9, Client #10, Client #11, and Client #12 on Post #1 (Client #12 was at the facility isolation house during the dates reviewed), in addition to Client #4.</td>
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Record review of the Rainier School Staff Communication Sheet for 1040 QC, dated 09/18/20, showed five staff assigned to the PM shift until 5:00 PM when Staff G, AC, completed her shift. At 5:00 PM, Staff N, AC, took over the responsibility of Client #4 as well as kitchen duties for the evening meal.

-Client #4’s IHP, dated 01/29/20, showed he required protective line of sight of staff unless he was in his room. Client #4 had alarms on his window and door to alert staff so they could promptly respond. Client #4 had a limited understanding of his own safety needs, had a history of unprovoked aggression and would drink and touch hot objects if unsupervised.

- Record review of Client #9’s PBSP, signed 05/05/20, showed Client #9 was blind, would strike others, kick, scratch, forcefully push, or twist other’s arm or wrist. It identified that when Client #9 felt threatened or over stimulated he was more likely to become aggressive toward others.

-Client #10’s PBSP, signed 12/16/20, showed she would hoard items that were not hers, made verbal threats, and would exhibit physical aggression towards others. The PBSP instructed staff to "Regularly, try to give her your undivided attention."
### Statement of Deficiencies and Plan of Correction

**State of Washington Department of Social and Health Services**

**Center for Medicare & Medicaid Services**

**Name of Provider or Supplier:** Rainier School Pat C

**Street Address, City, State, Zip Code:** Ryan Road Buckley, WA 98321

**Provider's Plan of Correction**

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<tr>
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<td>Continuation from page 21</td>
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<td>- Client #11's IHP, dated 02/05/20, showed he was blind, had SIB (striking his head with his hand or intentionally striking his head against hard objects), and showed aggression (scratching, pinching, hitting, kicking, and pulling hair). During an interview on 10/07/20 at 9:57 AM, Staff J, ACM, Staff K, Qualified Intellectual Disability Professional (QIDP), and Staff L, Developmental Disabilities Administrator 2 (DDA2), was asked how three staff would provide the care and supervision needs of the assigned Clients, they stated that with only three staff working the staff would have to share the responsibility of all the Clients at the house. That would include staff prioritizing Client needs and potentially having to supervise more than one Client at a time, even if the Client required a 1:1 staff (one staff assigned to care for only one Client) and staff would need to rely on the facility BRT to assist with any Client behaviors. One staff assigned to Post #5 (three staff working) Review of 1040 QC post assignments showed one staff assigned to Post #5 to provide care and supervision to only one Client, Client #2. - Client #2's IHP, dated 04/21/20, showed he required a dedicated staff to remain within arm's reach of him whenever he was around food or when he approached another Client. Client #2 was able to be alone in his room with a door alarm activated; staff were to resume his supervision as soon as he left the room. The IHP identified inappropriate sexual behaviors towards other Clients and stealing items as behaviors</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE**
RYAN ROAD
BUCKLEY, WA 98321

**ID PREFIX TAG**
**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**W 186**

Continued From page 22
requiring the one staff to one Client (1:1) ratio.

Review of Rainier School Staff Communication Sheets for 1040 QC, dated 09/17/20-09/20/20 showed:
On 09/17/20 on both AM shift and PM shift, no staff assignment to Post #5 to provide care and supervision for Client #2.
On 09/18/20 on the AM shift, no staff assignment to Post #5 to provide care and supervision for Client #2.
On 09/19/20 on the AM shift, no staff assignment to Post #5 to provide care and supervision for Client #2.
During an interview on 10/07/20 at 9:57 AM, Staff J, ACM, stated that Client #2 should always have an assigned staff to provide his 1:1 supervision needs and the information should be on the Staff Communication Sheets.

Night shift

Record review of the night shift Post assignments for 1040 QC showed three different staff assignments.

During an interview on 09/29/20 at 11:40 AM, Staff J, ACM, stated that 1040 QC should have three staff on the night shift.

Post #1 assignment included the care and supervision of Client #3, Client #4, Client #7, Client #8 (in hospital), Client #10, and Client #12 (isolation house). Staff were to respond to Client
W 186 Continued From page 23

#3's alarm and follow him if he left the house, respond to Client #4's alarm and follow him if he left the house, and assist Client #7 with toileting.

Post #2 assignment included the care and supervision of Client #1, Client #2, Client #5, Client #6, Client #9, and Client #11. Staff were to respond to Client #5's alarms and follow her if she left the house, and also respond to Client #2's door alarm and provide 1:1 line of sight when he was out of his room.

Post #3 assignment did not include any care or supervision of Clients; staff assigned were to help where needed.

Record review of Rainier School Staff Communication Sheet for 1040 QC, dated 09/17/20, showed two staff assigned to the night shift.

Record review of Rainier School Staff Communication Sheet for 1040 QC, dated 09/18/20, showed two staff assigned to the night shift. At 3:52 AM, the staff attempted to assist the Clients out of the house due to an unscheduled fire alarm. Staff documented "See [Client #3's initials] file + [Client #7 initials] blue file."

Record review of Client #3's Active Treatment notes, dated 09/19/20, showed Client #3 declined to leave the house when the fire alarm went off and he remained in his room. Staff documented that staff monitored Client #3 for security purposes.

Record review of Client #3's IHP, dated 01/15/20, showed Client #3 did not like to leave the house.
W 186 Continued From page 24
and disliked the noise of the fire alarm and needed significant support of staff to evacuate the house during an emergency.

Record review of Client #7's Interdisciplinary Progress Notes, dated 09/19/20, showed Client #7 declined to leave the house when the fire alarm went off and was combative with staff.

Record review of Client #7's IHP, dated 06/22/20, showed Client #7 required a wheelchair and staff assistance to ensure he was able to respond quickly to all evacuations.
Exhibit D
Important Notice - Please Read Carefully

Mike Crane, Superintendent
Rainier School P.A.T. C
P O Box 600
Buckley, WA  98321

RE:  Third Revisit Recertification Survey from 06/15/2022 through 06/29/2022
   ASPEN Event ID: KFRI14

Dear Mr. Mike Crane:

From 06/15/2022 through 06/29/2022 survey staff from Residential Care Services (RCS) Division of the Aging and Long-Term Support Administration (ALTSA) conducted a third revisit recertification survey at your facility. Based on that visit, RCS determined that Rainier School Pat C is out of compliance with federal conditions of participation (COPs) requirements for ICFs/IID participating in the Medicaid Title XIX ICF/IID program. The non-compliance posed an immediate jeopardy (IJ) to the health and safety of the clients at Rainier School Pat C.

Immediate Jeopardy (42 CFR 442.117 & SOM 3010B)
On 06/16/2022, you were verbally informed that RCS had determined that Rainier School Pat C’s noncompliance posed an immediate jeopardy to resident health and safety. The CMS Form 2567 statement of deficiencies is enclosed with this letter. This Immediate Jeopardy was verified removed on 06/27/2022.

Compliance with COPs
Compliance with all COPs, found in 42 Code of Federal Regulations (CFR) 483 Subpart I, is required for certification. The third revisit recertification survey completed on 06/29/2022, found that Rainier School Pat C failed to comply with the following COP:

W102 – 42 CFR 483.410 Governing Body and Management
W122 – 42 CFR 483.420 Client Protections
The deficiencies are described in CMS Form 2567, a copy of which is attached. The cited deficiencies indicate limitations in Rainier School Pat C’s capacity to provide adequate services for clients.

The State Medicaid Agency/Health Care Authority (HCA) will be in communication with Rainier School PAT C regarding a transition plan for clients.

**Informal Dispute Resolution (IDR)**

You may request an IDR of the deficiencies on which this action is based. RCS must receive your request for an IDR within 10 calendar days of receiving this letter. To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a written credible allegation of compliance within the time limits described above. The written IDR request should:

1. Identify the specific deficiencies that are disputed;
2. Explain why you are disputing the deficiencies; and
3. Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review)

If requested, an IDR will be scheduled. During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. The IDR process will not change the time frames stated in this letter, including the deadlines for achieving compliance and submitting a written credible allegation of compliance.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 890-1491.

Sincerely,

Gerald Heilinger, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services

Enclosure
This report is the result of a Revisit Survey conducted at Rainier School PAT C. The entrance conference was conducted on 6/15/2022. A sample of 6 Clients were selected. The sample was expanded and added 32 Clients. The exit conference was completed on 06/29/2022. Failed provider practices were identified, and citations were written.

An Immediate Jeopardy was declared on 06/16/2022 at 3:24 PM. The Program Area Team (PAT) Director, Medical director, and the Director of Nursing, who had oversight of the facility, failed to ensure staff followed Washington State Administrative Codes, facility policies, procedures and standard nursing practices when treating Client 5 who developed an infection in their left eye.

The facility was directed to devise a plan to address the Immediate Jeopardy situation.

According to the submitted plan, the facility's governing body met and created a triage team that would oversee all new medical treatments prescribed to Clients and all medical treatment refusals. The Triage team would ensure that all medical treatments, new and refusals, were documented immediately and accurately. The Triage team would ensure that the facility physicians were made aware of any potential barriers to Clients taking the new treatments or if Clients were refusing current treatments. The Triage team would ensure that a training plan was put in place so that all Clients received their prescribed treatments. All of the nursing staff, medical staff, and pharmacy staff were trained on...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 50G047

**Date Survey Completed:** 07/14/2022

**Multiple Construction**

<table>
<thead>
<tr>
<th>A. Building</th>
<th>B. Wing</th>
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**Name of Provider or Supplier:** Rainier School Pat C

**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

**Summary Statement of Deficiencies**

**Condition:** W 000

- Continued From page 1
- their reporting requirements to the new Triage team and how to properly document medical treatments/refusals in the Clients' files.

- Based on the submitted plan, the facility was notified the Immediate Jeopardy had been removed on 06/27/2022 at 2:00 PM. However, deficient practice with Condition level findings remained.

**Condition:** W 102

- **Governing Body and Management**
  - CFR(s): 483.410

- The facility must ensure that specific governing body and management requirements are met.

- This CONDITION is not met as evidenced by:
  - Based on observation, record review, and interview, the facility's governing body did not:
    - ensure that Clients' right were protected per the requirements for the Condition of Participation for Client Protections for 1 of 6 Sample Clients (Clients 5) and 2 Expanded Sample Clients (Clients 7 and 9) did not ensure Clients received Active Treatment per the requirements for the Condition of Participation for Active Treatment for 4 of 6 Sample Clients (Clients 1, 2, 3, and 4) and 1 Expanded Sample Clients (8) and did not provide health care services that addressed known health concerns in a way that worked to effectively treat illnesses and prevent serious medical outcomes for the Condition of Health Services for 2 of 6 Sample Clients (Clients 4 and 5) and 24 Expanded Sample Clients (Client 11, 12, 13 and 17 - 38). These failures placed Clients' rights and safety at risk, kept Clients from...
W 102 Continued From page 2
receiving training to increase their independence, and put Clients' health at risk.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021.

Findings included ...

Observation, record review, and interview showed Client 5 was neglected when they were not provided appropriate medical care to treat their eye infection which resulted in the loss of their left eye. This resulted in Immediate Jeopardy. A Corrective Action Plan was not created after Client 5 suffered from medical neglect. Clients were subjected to psychological harm and neglect and facility staff were not reporting these incidents. These failures prevented Clients from living in a safe environment where they were free from abuse and neglect and their medical needs were met. Refer to W122 for more details.

Observation, record review, and interview showed Clients were given training programs in skills they already knew how to do Clients weren't provided training on identified needs a Client did not receive an audiological exam a Client's program contained instructions that could not be carried out a Client did not receive training in daily living activities a Client's programs were not implemented as written and Clients were restricted without proper authorization. These failures resulted in no active treatment for Clients 2, 3, 4 and 8, and inadequate training which prevented Client 1 from becoming as independent as they could to live in the least restrictive setting possible. Refer to W195 for more details.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 50G047

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

R 0/29/2022

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<td>W 102 Continued From page 3</td>
<td>Observation, record review, and interview showed medical assessments were not completed for Clients that refused and no plan was created to ensure the assessments were completed the facility's physicians did not complete exams or review Clients’ files to ensure they received treatment in line with their needs the facility's nursing department did not communicate Clients medical needs to direct care staff or the interdisciplinary team (IDT) the facility's nursing department did not communicate with the facility physicians when Clients refused treatments and the facility's medical department did not ensure Clients who were over 50 years old received a second booster shot for COVID-19 as recommended by the Center for Disease Control. These failures resulted in Client 5 having their left eye surgically removed, permanent disfigurement, and less visual ability and 26 Clients did not receive the recommended treatment for COVID-19. Refer to W318 for more details.</td>
<td>W 102</td>
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<tr>
<td>W 104 GOVERNING BODY CFR(s): 483.410(a)(1)</td>
<td>The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to create and implement systemic changes to come into compliance with the federal regulations for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) following a Recertification Survey completed 05/06/2021, a Revisit Survey completed on</td>
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**W 104** Continued From page 4

07/14/2022, an alternate remedy period of up to 11 months imposed on 08/04/2021, and two additional Revisit Surveys completed on 04/12/2022 and 06/29/2022. In each of these survey visits the facility was cited as non-compliant with the Condition level regulations with W122 - Client Protections, W195 - Active Treatment, and W318 Health Care Services. W102 - Governing Body was cited as non-compliant in two of the four surveys. This failure placed all Clients at risk for harm from the lack of essential services in the areas of Client Protections and Health Care Services, and from receiving the training in independence required by the regulations.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021.

Findings included ...

Record review of Developmental Disabilities Administration Policy 17.04 "Governing Body", dated 08/15/2021, showed that the Residential Habilitation Center (RHC) governing body included the Superintendent and Rainier Program Area Team (PAT) C Director (formerly known as Developmental Disabilities Administrator 2).

Record review of the "Developmental Disabilities Administrator 2 Position Description Form", dated 08/07/2008, showed that this position was responsible for developing and delivering quality residential habilitation and vocational services. They were responsible for implementing policies and procedures to ensure compliance with all state and federal regulations including federal certifications as an ICF-IID. They were also to oversee the risk management/incident ...
W 104 Continued From page 5
management system that included daily incident
management meetings, discussions of incident
reports, Client-to-Client altercations and injury
reports with immediate protection plans as
needed and assign and review final closure of all
incidents.

Record review of the "Superintendent Exempt
Position Description", dated 09/2005, showed that
the positions' responsibilities were leadership,
planning, program quality management,
stakeholder relationships, Organizational
development and management, Operational
control and management, and Human resource
development and personnel administration. This
positions' job duties showed 25% of their
responsibilities were to "Meet state, federal and
local regulations that govern and monitor health,
safety, programmatic, legal and regulatory
requirements. Provide state of the art residential
treatment services consistent with recognized
best practices." 35% was dedicated to "Supervise
and support employees, including providing
effective training, communication, information,
evaluations completing personnel investigations,
corrective and disciplinary actions as needed.
Participate in grievance, mediation activities and
post disciplinary action to ensure consistent
enforcement of performance/ethical standards
associated with the provision of human services."

Record review of the Statement of Deficiency
ASPEN number KFR111 (a federal database for
tracking survey outcomes), dated 05/06/2021,
showed the facility was out of compliance with the
ICF/IID Federal regulations for the Conditions of
Participation in W122 - Client Protections, W196 -
Active Treatment, W318 - Health Care Services
and W102 - Governing Body.
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| W 104 | Continued From page 6 | W 104 | Record review of the Statement of Deficiency with ASPEN number KFRI12, dated 07/14/2021, showed the facility was out of compliance with the ICF/IID Federal regulations for the conditions of participation in W122 - Client Protections, W196 - Active Treatment, and W318 - Health Care Services. | | | | | Record review of the Statement of Deficiency with ASPEN number KFRI13, dated 04/12/2022, showed the facility was out of compliance with the ICF/IID Federal regulations for the conditions of participation in W122 - Client Protections, W196 - Active Treatment, and W318 - Health Care Services. | | | | Record review of Statement of Deficiencies for Complaint investigations from 06/11/2021 to 06/01/2022, showed the facility had been cited for not protecting Clients from abuse, neglect, and mistreatment 11 times during that time period. | | | | During an interview on 06/28/2022 at 1:30 PM, Staff B, Program Area Team Director (Developmental Disabilities Administrator 2) stated that they were aware and knew of their responsibilities to ensure compliance with the federal regulations. When asked if there were written polices or procedures on how they would complete these tasks, they stated that they didn’t know of any written instructions and that they had learned the job from previous employees who had occupied the position of Developmental Disabilities Administrator 2. Staff B was promoted to this position in March of 2022. | | | | During an interview on 06/28/2022 at 2:00 PM, Staff C, Superintendent, stated that they were
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<td>W 104</td>
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Aware and knew of their responsibility to ensure compliance with the federal regulations. When asked if there were any written policies or procedures on how they could complete these duties, they stated that they didn’t know of any written directions to accomplish this task and they stated that they learned the job from a previous staff who held the position of Superintendent. Staff C was promoted to this position on February 16th, 2022.

**W 122**

**CLIENT PROTECTIONS**

CFR(s): 483.420

The facility must ensure that specific client protections requirements are met.

This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their systems to prevent abuse, neglect, and mistreatment protected 1 of 6 Sample Clients (Client 5), and 2 Expanded Sample Clients (Clients 7 and 9). A Client was neglected when they were not provided appropriate medical care to treat their eye infection which resulted in the surgical removal of their left eye. A Corrective Action Plan was not created after a Client suffered from medical neglect. Clients were subjected to psychological harm and neglect, and the facility staff did not report these incidents to the facility administration or to State Complaint Resolution Unit (CRU). These failures prevented Clients from living in a safe environment where they were free from abuse and neglect and their medical needs were appropriately cared for.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**
RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
RYAN ROAD
BUCKLEY, WA 98321

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<tr>
<td>W 122</td>
<td>Continued From page 8</td>
<td>This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021, KFRI12 Revisit survey on 07/14/2021, and KFRI13 Revisit survey on 04/12/2022. Findings included ... Record review and interview showed the facility did not ensure that Client 5 received appropriate medical care for an eye infection that resulted in surgical removal of the eye. Refer to W127 for more details. Observation, record review, and interview showed observations by State Surveyors that Client 7's supervision level was not followed according to their Positive Behavior Support Plan and Client 9 was subjected to possible psychological harm when a staff yelled loudly at them. These incidents were not reported for investigation by staff to the facility or to the State CRU for reporting abuse. Refer to W153 for more details. Record review and interview showed the facility did not create a Corrective Action Plan following an investigation into Client 5's medical interventions following a left eye infection, which resulted in the surgical removal of their left eye. Refer to W157 for more details.</td>
<td>W 127</td>
<td>PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5)</td>
<td>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</td>
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<td>W 127</td>
<td>Continued From page 9</td>
<td>This STANDARD is not met as evidenced by: Based on observations, record review, and interview the facility failed to ensure 1 of 6 Sample Clients (Client 5) received routine and emergent medical care for their eye infection. The facility's treatment plan lacked thoroughness, consistent monitoring, and the lack of symptom improvement with the treatment was not communicated to the facility physician. This failure resulted in Client 5 spending 13 days in the hospital and ultimately the removal of their left eye.</td>
<td>W 127</td>
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This is a repeat citation from the KFR11 Recertification survey on 05/06/2021, KFR12 Revisit Survey on 07/14/2021, and KFR13 Revisit survey on 04/12/2022.

Findings included ...

Record review of the facility's 5-Day Investigation Report 10190, dated 6/08/2022, showed Client 5 was seen by the facility physician on 05/16/2022 for a left eye irritation with crusty and clear drainage. The facility physician noted the left eye was "red and draining for the last 24-48 hours. Left eye (limited exam due to lack of cooperation and combative) Conjunctiva (mucous membrane that covers the front of the eye and lines the inside of the eyelids) and sclera (the part of the eye commonly known as the white) appear erythematous (superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.) Thick drainage noted in corner of eye. Unable to assess visual acuity or red reflex, of fundal exam. External and lids WNL (within normal limits)." The facility physician prescribed antibiotic eye drops to treat Client 5's condition.
**Record review of Client 5’s Interdisciplinary Team (IDT) meeting notes, dated 03/22/2022, showed Client 5 had a history of refusing eye drops. They were tactile defensive (hypersensitivity to touch) and became extremely stressed and resistive to hands-on training and treatment unless it was very brief. It showed if they said no to a request, they would not change their mind. It showed if Client 5 refused eye drops the IDT did not recommend restraining them to administer drops. Client 5 has a service care plan (SCP) to address avoidance of chaotic environments as they are more apt to accept their eye drops if, the environment was quiet, they were seated in a chair, and demonstrated acceptance of the procedure.**

**Record review of Rainier School’s Medication Administration Procedure, dated 01/25/2022, showed if medications were refused, the nurse’s initials would be circled in the appropriate time/date block on the Medical Administration Record (MAR) and the refusal documented on the back of MAR. Each occurrence of a refusal was to be documented on the back of the MAR. The nurse must notify the RN of the incident, who would then evaluate the situation and would notify the facility physician by phone for medications of significant impact i.e., cardiac, seizure, insulin or breathing treatment, or by telephone/voicemail of routine medications i.e., multivitamins, vitamin C or stool softeners. Multiple refusals would require notification of the pharmacist by email for review and replacement.**

**Record review of Client 5’s Medication Administration Record (MAR), dated May of 2022, showed Client 5 received only 3 doses of...**
W 127 Continued From page 11
the 20 prescribed antibiotic eye drop doses. Nursing staff did not consistently use the required code for when the Client refused the eye drops, and did not complete the back of the MAR regarding the context of the refusals as required by facility policy. Notifications were not consistently made to a Registered Nurse (RN), physician, or the pharmacy regarding the refusals as required by facility policy.

Record review of Client 5's IDT note, dated 03/22/2022 showed that a Habilitation Plan Administrator (HPA), Attendant Counselor Manager (ACM), Registered Nurse (RN), Psychology Associate, Advanced Registered Nurse Practitioner (ARNP), Medical Transcriptionist, Clinical Pharmacist, and a Licensed Practical Nurse (LPN) attended the meeting and discussed Client 5's historical refusal of eye drops. Client 5's file showed no communications from any of these departments or individuals to the facility physician regarding, the historical refusal of eye drops for, the antibiotic eye drops ordered for Client 5's conjunctivitis (Inflammation of the transparent covering of the eye because of bacterial or viral infection or allergic reaction) on 05/16/2022.

Record review of Client 5's Health Progress Notes, dated 05/17/2022 at 8:15 AM, showed Staff H, RN noted Client 5 started on antibiotic eye drops and that they had not been cooperative when attempting to administer the eye drops. Client 5 would not allow nurses to cleanse eye drainage.

Record review of Client 5's Health Progress Notes, dated 05/18/2022 at 9:50 PM, showed Staff I, LPN, noted Client 5's remained irritated.
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<td>W 127</td>
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<td>Continued From page 12 and eye drops were attempted. They noted the eye drops were difficult to give to Client 5. Record review of Client 5's Health Progress Notes, dated 05/19/2022 at 7:20 PM, showed Staff J, ARNP, noted Client 5's left eye was still red and had drainage. Client refused their attempt to administer the eye drops. They stated that Client 5 was at risk for infection and that they would continue to monitor. Record review of Client 5's Health Progress Notes, dated 05/21/2022 at 7:55 PM, showed Staff G, LPN, noted Client 5's left eye still had conjunctivitis and was red with drainage. The note contained no information about whether Client 5's antibiotic eye drops were attempted. Record review of Client 5's Health Progress Notes, dated 05/22/2022 at 8:00 AM, showed Staff H, RN, noted Client 5's left eye had not worsened but still did not look completely healed. Client 5 was not cooperating with their antibiotic eye drops or their prescribed eye drops for glaucoma (A condition where the eye's optic nerve, which provides information to the brain, is damaged with or without raised pressure.) Staff H determined that since Client 5 refused eye drops so much of the time that the benefit was limited. Staff H discontinued the charting for the left eye conjunctivitis. Record review of Client 5's Health Progress Notes from 05/22/2022 at 9:00 AM through 05/29/2022 at 8:15 AM, showed no documentation regarding Client 5's left eye conjunctivitis was provided. Record review of Client 5's Health Progress Notes, dated 05/29/2022 at 8:15 PM, showed Staff H, RN, noted Client 5's left eye conjunctivitis was not documented in the charting. They noted the eye drops were difficult to give to Client 5.</td>
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### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:**
RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
RYAN ROAD
BUCKLEY, WA 98321

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<td>Notes, dated 05/29/2022 at 8:20 PM, showed Staff G, LPN, noted Client 5 had left eye redness and drainage still. They noted Client 5 was uncooperative and became difficult when attempting to clean their eyes and apply warm compress. Staff H noted that Client 5 was at risk for infection. They stated that a Registered Nurse (RN) was notified.</td>
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<td>Record review of Client 5's Health Progress Notes, dated 05/29/2022 at 9:00 PM, showed Staff K, RN, noted that Client 5's left eye remained reddened and continued to have large amounts of thick white drainage. They noted that Client 5 was at risk of conjunctivitis and that the treatment for this condition was ended on 5/22/2022. Staff K stated that the writer had notified the facility clinic via email.</td>
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<td>Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 12:06 PM, showed Staff F, Physician, noted a follow up to Client 5's conjunctivitis. It showed that Client 5 continued to have a swollen lid and discharge from their eye. Staff F noted Client 5 would not allow an exam of their eye. Staff F prescribed a different antibiotic eye drop for Client 5. The Physician noted that Client 5 should be considered for an ophthalmology consult.</td>
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| Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 4:15 PM, showed Staff L, RN, completed a Rainier School injury and fall assessment on Client 5. It showed that Client 5 had an unwitnessed fall in their bedroom. It noted Client 5 had a red area on the back of their head. It noted Client 5 was awake, alert, oriented, and vocalizing per usual. Staff L reported the swelling was about the size of a
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<td>plum and that there was no bleeding noted. Staff L documented they did not see any change in cognition or vision for Client 5.</td>
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<td>Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 4:46 PM, showed Staff F, Physician, noted an addendum to their previous order. It stated that given the difficulty of administering eye drops, with Client 5, and the possibility of periorbital/perceptual cellulitis (an infection of the eyelid or the skin around the eye), they will start a course of oral antibiotics for Client 5.</td>
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<td>Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 6:15 PM, showed Staff M, LPN, noted that Client 5 was on alert charting for their left eye conjunctivitis to monitor drainage, swelling, Client 5's cooperation with treatment and using a warm compress. Staff M noted Client 5 refused the compress. Client 5 took their oral antibiotic medication. Staff M noted drainage from Client 5's left eye as well as swelling.</td>
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|           |     | Record review of a Clinical Note Entry, dated 06/01/2022 at 9:30 AM, showed Staff J, ARNP, saw Client 5 at their house to follow up on the left eyelid swelling. They noted that Client 5's left eyelid was swollen to the point that they could not open their eye. Staff J noted the presence of erythematous (superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilation of the blood capillaries.). They noted yellow thick drainage on the corner of Client 5's left eye. The right eye was reported to be within normal limits. Staff J noted that an oral antibiotic was started. Staff J reported that they had a concern for orbital cellulitis (an infection of
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
RAINIER SCHOOL PAT C

#### Multiple Construction
A. Building ___________________________
B. Wing ___________________________

#### Provider’s Plan of Correction
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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<td>(X4) W 127</td>
<td>Continued From page 15 the eyelid or the skin around the eye) in Client 5’s left eye. Staff J wrote an order to send Client 5 out via ambulance for evaluation and a possible CT (Computerized Tomography - a technique for displaying a representation of a cross section through a human body or other solid object) scan. A sedation order was filled out so Client 5 could be transported via ambulance to St. Elizabeth’s Emergency Department. Staff J informed the interdisciplinary team (IDT) and guardian about the transfer. Record review of Client 5’s UW Medicine Harbor Medical Center Discharge Summary, dated 06/13/2022 at 10:50 AM, showed on 06/10/2022 the hospital completed surgery to remove their left eye. During an interview on 06/15/22 at 5:30 PM Staff A, Registered Nurse, stated that all of the Health Progress Notes, MARs, Physicians Orders, and Clinical Notes contained in the 5-day investigation were directly quoted from those documents. They verified that there were no Health progress notes from 5/22/2022 through 5/31/2022 regarding Client 5’s eye condition. During an interview on 06/16/2022 at 11:30 AM, Staff B, Program Area Director, Staff C Superintendent, Staff D, RN, and Staff E, Medical Director, stated that there were several instances where nursing staff did not follow the facility’s policies and procedures when Client 5 refused their antibiotic eye drops. They stated that the IDT was not consulted or informed about the Client’s new medical condition. They stated that the facility did not have a plan in place to deal with Client 5’s refusal of medical assessments or treatments.</td>
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<td>(X5) W 127</td>
<td>Would you like to see a summary of the plan of correction for this violation? If yes, please enter the ID, PREFIX, and TAG.</td>
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Form CMS-2567(02-99) Previous Versions Obsolete
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Facility ID: WA40090
If continuation sheet Page 16 of 83
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| W 153         | STAFF TREATMENT OF CLIENTS

CFR(s): 483.420(d)(2)

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure facility staff reported an allegation of potential abuse, neglect, or mistreatment of 2 of 2 Expanded Clients (Client 7 and Client 9) to facility administration. This failure resulted in the facility being unable to protect the Clients from the alleged perpetrators and provide care to the identified Clients.

This is a repeat citation from KFRI11 Recertification survey on 05/06/2021 and the KFRI13 Revisit survey on 07/14/2022.

Findings included ...

Client 7

Observation on 06/17/2022 at 6:58 AM in Buckley House showed Client 7 was in the TV room alone. Staff P, Attendant Counselor (AC), was in the dining room helping Client 11 heat up their breakfast and serve it.

Record review of Client 7's Positive Behavior Support Plan (PBSP), dated 10/21/2021, showed that Client 7 required significant staff assistance, required staff keep them within their line of sight, and within arm's reach, if the Client was standing...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

#### Summary Statement of Deficiencies

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- **W 153** Continued From page 17
- or walking. Client 7 required staff supervision to help prevent falling to prevent them from being aggressive with other Clients and with staff to prevent them from harming themselves, destroying property, being disruptive, exhibiting inappropriate behaviors and to help them maneuver around the house because they were blind.

- Record review of Rainier School Staff Communication Sheet for Buckley House, dated 06/17/2022, showed Staff P was assigned to work Post #4. The communication sheet showed that from 6:15 AM-7:25 AM, four staff were assigned to care for the eight Clients at the house, including Client 7.

- Record review of the Post #4 staff position schedule, undated, showed Client 7 required 1:1 staff supervision (1 staff assigned to provide care and supervision to only Client 7).

- Observation at Buckley House on 06/17/2022 at 7:09 AM showed that Staff P went into the TV room and brought Client 7 to the dining room from the TV room.

- During an interview on 06/17/2022 at 7:20 AM, Staff P stated that Client 7 required 1:1 staff supervision. When asked if staff provided the Client's required supervision, Staff P stated that there were not enough staff at that time.

- During an interview on 06/17/2022 at 9:02 AM, Staff S, Attendant Counselor Manager (ACM), was notified that Staff P did not provide Client 7 with their required supervision on 06/17/2022 from 6:58 AM-7:09 AM.
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<td>During an interview on 06/23/2022 at 9:17 AM, Staff R, Investigator 3, stated that the incident management office did not have a record of being notified of a potential allegation of neglect related to Client 7 not receiving their required staff supervision on 06/17/2022.</td>
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<td>During an interview on 06/28/2022 at 4:00 PM, Staff S, ACM, stated that they did not report Staff P's lack of supervision to facility administration.</td>
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<td>Client 9</td>
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<td>Observation on 06/21/2022 at 4:48 PM in Devenish House showed Client 9 went in and out of the exterior door located at the end of the hall between the kitchen on A side and the front room on B side then walked around the interior of the house to return to the same door and go outside. Staff N, AC, followed Client 9 around the house. When the door closed, Staff N opened the door and looked out at Client 9. State Surveyor 2 shifted their focus to continue observation of another client. At this point Staff N stated, &quot;What the Hell &quot; in a loud and angry tone. State Surveyor 2 immediately turned their head to look in the direction of the voice and made eye contact with Staff N for several seconds, who then turned to the exterior door, pushed it open and stated, &quot;That hurt dude &quot; in the same loud and angry tone. Client 9 entered the house and went into the living room on the B side followed by Staff N. State Surveyor 2 then searched the house for Staff O, ACM, who was in the dining area on the A side of the house. At 4:51 PM, State Surveyor 2 reported to Staff O, ACM, the interaction observed three minutes prior between Client 9 and Staff N.</td>
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## Observation on 06/21/2022 at 5:05 PM

Observation on 06/21/2022 at 5:05 PM in Devenish House showed Staff N returned to the living room on B side where Client 9 watched television after speaking with Staff O. Staff N resumed supervision of Client 9.

Record review of an email sent to Staff R, Investigator 3, at 1:49 PM on 06/22/2022 by State Surveyor 2 showed a request for the incident report related to Client 9 and Staff N for the incident on 06/21/2022. The reply by Staff R at 1:53 PM on 06/22/2022 showed the Incident Management Office did not have an incident report for Client 9 and a staff on 06/21/2022.

During an interview on 06/22/2022 at 2:09 PM, Staff R stated that there was no incident report for the interaction observed by State Surveyor 2 between Staff N and Client 9 on 06/21/2022 at 4:48 PM. State Surveyor 2 then reported the incident to Staff R who stated that they would create the incident report and notify the Complaint Resolution Unit (CRU).

During an interview on 06/29/2022 at 8:49 AM, Staff O stated that after State Surveyor 2 notified them of the incident they observed on 06/21/2022 at 4:48 PM between Client 9 and Staff N, they notified their supervisor and followed their instructions. Staff O stated that their supervisor, Staff B, Program Area Team Director, determined that since Staff N's comments were a normal reaction and not directed at Client 9, that no incident report was written.

During an interview on 06/29/2022 at 8:55 AM, Staff B stated that Staff O called them and informed them of the incident on 06/21/2022 between Client 9 and Staff N as witnessed by...
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<td>State Surveyor 2. Staff B stated that they understood Staff N reacted to almost getting their fingers shut in the door and had a natural reaction to that circumstance and did not direct their comments at Client 9. Staff B stated that they thought State Surveyor 2 would call the facility Incident Management Office, an incident report would be created, and an investigation would begin. Staff B stated that the person who observed the incident needed to write the incident report. Staff B stated that they instructed Staff O to have a conversation with Staff N regarding professionalism and maintaining appropriate behavior despite the circumstances.</td>
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<td>Record review of an email response sent by Staff B to State Surveyor 2 on 06/29/2022 at 10:58 AM showed, &quot;Also DDA (Developmental Disabilities Administration) policy 5.13 states those who witness the incident must make the CRU call.&quot; An excerpt from this policy was included that showed, &quot;When a DDA employee, contractor, volunteer, intern, or work study student in the course of their duties has reasonable cause to believe that any client has been abused, neglected, or exploited, regardless of the source of information, they must call the appropriate DSHS reporting unit (see Section C below) immediately.&quot; There was no Section C included with the email.</td>
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<td>W 157</td>
<td>STAFF TREATMENT OF CLIENTS</td>
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<td>CFR(s): 483.420(d)(4)</td>
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<td>If the alleged violation is verified, appropriate corrective action must be taken.</td>
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<td>This STANDARD is not met as evidenced by:</td>
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Based on record review and interview, the facility failed to create a corrective action plan after 1 of 6 Sample Clients (Client 5) was transported to the hospital where their left eye had to be surgically removed. The facility's 5-Day Investigation determined that the incident likely could have been prevented if Client 5 had received their prescribed medical care and nursing had communicated the Client's refusals with their facility physician at the facility. This failure resulted in all Clients being at risk of their medical needs not being properly assessed and treated.

Findings included ...

Record review of facility 5-Day Investigation Report #10190, dated 06/08/2022, showed the following:

Client 5 had a well-documented history of refusing the administration of eye-drops related to their eye conditions of glaucoma (a condition where the eye’s optic nerve, which provides information to the brain, is damaged with or without raised pressure,) and cataracts (clouding of the normally clear lens of the eye). On 05/16/2022 Client 5 was seen in the clinic for redness and swelling to their left eye. Client 5 refused the facility physician’s exam, the physician suspected a diagnosis of conjunctivitis (Inflammation of the transparent covering of the eye because of bacterial or viral infection or allergic reaction,) and ordered antibiotic eye-drops. Client 5 did not receive the full course of the antibiotic eye-drops due to repeated refusals and the refusals were not reported to the facility physician, so a plan could be developed to ensure Client 5 received their prescribed treatment.
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**Summary Statement of Deficiencies**

The initial diagnosis of left eye conjunctivitis (Inflammation of the transparent covering of the eye because of bacterial or viral infection or allergic reaction,) was not resolved and treatment was stopped. On 05/22/2022 the Primary Care Nurse discontinued the charting, stopped the Acute Nursing Care Plan, and wrote a progress note that the eye was not fully healed. No follow-up medical care was requested.

On 05/29/2022 the licensed Practical nurse (LPN) reported to the registered nurse (RN) that Client 5's left eye had increased redness and drainage. The RN sent an email to clinic staff to have Client 5 seen in the clinic on the next business day. An additional email was sent by an LPN on 05/30/2022 to clinic staff regarding increased redness and drainage of the left eye.

Client 5 was seen in the clinic on 05/31/2022 and a different antibiotic drop was ordered to treat conjunctivitis.

Later in the day on 05/31/2022 the RN contacted the physician concerning Client 5's refusal of eye drops. The physician made an addendum to the order, now diagnosing Client 5 with periorbital/preseptal cellulitis (infection of the eyelid or skin around the eye) and ordered an oral antibiotic.

Client 5 was transported to the hospital on 06/01/2022 after their left eye was assessed by the facility's Advanced Registered Nurse Practitioner.

Client 5's eye infection could have likely been prevented if Client 5 had received appropriate medical care sooner.
W 157 Continued From page 23

medical care prior to the hospital transfer. No
nursing orders were in place to guide medication
and treatment for licensed practical nurses or
direct care staff regarding the initial Acute Nursing
Care Plan. The antibiotic eye drops were
successfully administered only three times out of
the twenty ordered. No medical follow-up was
requested by nursing after the initial order was
treated. The gap in treatment of Client 5's left eye
may have led to the cellulitis infection.

Client 5 was diagnosed with Orbital Cellulitis and
retinal detachment in their left eye while at the
hospital. Client 5 had likely suffered pain and
discomfort and would most likely lose their left
eye.

During an interview on 06/16/2022 at 10:30 AM,
when asked if there was a corrective action plan
related to the facility's 5-Day Investigation
regarding Client 5's eye, Staff B, Program Area
Team (PAT) Director, stated that the facility was
working on an addendum to the investigation and
had not yet made a determination as to whether
facility systems had worked.

On 06/29/2022, State Surveyor 3 sent an email to
Staff B and Staff R, Investigator 3, requesting the
corrective action plan for the facility's 5-Day
Investigation regarding Client 5's eye. No
response was given to State Surveyor 3.

W 186 DIRECT CARE STAFF
CFR(s): 483.430(d)(1-2)

The facility must provide sufficient direct care
staff to manage and supervise clients in
accordance with their individual program plans.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

#### Summary Statement of Deficiencies

**W 186 Continued From page 24**

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 there were sufficient staff assigned to work at 1 of 7 Sample Houses (Buckley House) to meet the identified needs of the Clients at the house. This failure resulted in one Client not receiving their required supervision level and left the other Clients at risk for not having their needs met timely.

Findings included ...

Observation at Buckley House on 06/17/2022 at 6:52 AM showed a staff communication sheet listed 4 staff assigned to the house. At 6:54 AM Staff P, Attendant Counselor (AC), stated that there were 4 staff assigned to the house, and at work, at that time.

Record review of Rainier School staff communication sheet on 06/17/2022 at 6:54 AM showed 4 staff were assigned and present at the house to provide care and supervision of 8 Clients since 6:15 AM. Staff P was assigned to post #4, Staff JJ, AC, was assigned to post #6, Staff KK, AC, was assigned to post #7, and Staff LL, AC, would be assigned to post #2 when they arrived. No staff were assigned to post #1 and post #2, until Staff LL arrived, or post #5.

Record review of Rainier School Duty Office (responsible for staff assignments to houses) sheet, dated 06/17/2022, showed Buckley House required 7 Attendant Counselors (also known as...
### W 186

Continued From page 25

Direct Care Staff (DCS) on the AM shift. The sheet listed Staff P, Staff Q, Staff KK, and Staff JJ as the 4 staff at the house at the beginning of the morning shift. Two additional staff were scheduled to arrive at 7:30 AM, and two more were scheduled to arrive at 8:00 AM.

Observation at Buckley House on 06/17/2022 at 6:58 AM showed Staff P was in the dining room with Client 2, Staff KK was in the kitchen with Client 3, and Staff Q and Staff JJ were in the TV room on A-side of the house. Client 7 was in the B-side TV room alone until 7:09 AM when Staff P brought them to the dining room for breakfast.

Record review of Client 7’s Positive Behavior Support Plan (PBSP), dated 10/21/2021, showed they required a staff to provide line of sight supervision on the AM and PM shifts and staff should be within arm’s reach when Client 7 was standing or walking. Client 7 was completely blind and required significant staff assistance with all activities. Client 7 required a dedicated staff to prevent injury to themselves, staff, and other Clients at the house due to their physical aggression, property destruction, disruptive behaviors, and inappropriate sexual behavior.

During an interview on 06/17/2022 at 7:20 AM, Staff P verified that Client 7 required staff to keep them within their line of sight and staff were unable to do that on the morning of 06/17/2022. When asked if the Duty Office was aware of the staffing level at the house, Staff P stated, “Yes, they wanted to run us at 3.” When asked if the house had a plan for providing Clients with their required supervision and assistance when there were not enough staff at the house, Staff P stated, “We have emergency staffing for 5 and 6..."
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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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<tr>
<td>W 186</td>
<td>Continued From page 26 staff but not 3 or 4 staff &quot;. Record review of Buckley House Post Position Schedules (a description of the staff's responsibilities when assigned to the post) showed:</td>
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<td>Post #1, updated 10/2021, was to supervise and provide care to Client 11, identify clients for the nurse at all medication passes, complete kitchen/meal duties of the Food Service Worker (FSW) duties if the FSW was not available, and complete house cleaning duties. Client 11 did not require a dedicated staff assigned only to them.</td>
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<td>Post #2, updated 10/2021, was to supervise Client 12 by keeping them within staff's line of sight when sitting or lying down and remain within arm's reach of Client 12 when the Client was up walking, and complete house cleaning duties. Staff assigned to this post was dedicated to supervise Client 12 only.</td>
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<td>Post #3, updated 10/2021, was to supervise Client 13 by providing 1:1 staff ratio (1 staff assigned to care only for the 1 Client) and keep them within staff's line of sight.</td>
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<td>Post #4, updated 06/2020, was to supervise Client 7 by keeping them within staff's line of sight.</td>
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<td>Post #5, updated 02/2022, was to supervise Client 2 and Client 15, and complete house cleaning duties.</td>
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<td>Post #6, updated 10/2021, was to supervise Client 14 by remaining within arm's reach when up and moving and within line of staff's sight</td>
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### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Address:** Ryan Road, Buckley, WA 98321  
**Provider's Identification Number:** 50G047  
**Survey Date Completed:** 07/14/2022  

#### Summary Statement of Deficiencies

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<td>W 186</td>
<td>Continued From page 27 when in the bedroom and complete house cleaning duties. Staff was assigned to this post to supervise Client 14 only. Post #7, updated 10/2021, was to supervise Client 3 by keeping them within staff's line of sight 24 hours a day. Staff was assigned to this post to supervise Client 3 only. Record review of Post #1 assignment for Buckley House for working with 6 staff instead of the 7 required, updated 06/2020, showed Post #1 would be required to care for Clients 3, 11, and 15 and kitchen duties when a FSW was not working. It showed that if the house had less than 6 staff working it was considered &quot;emergent&quot; and the Duty Office should be notified. Client 3 required staff to go with them when they left the house because they would eat cigarettes and Client 3 had physical aggression, would disrupt the environment, would destroy property, and was verbally aggressive. It did not identify how the staff would provide the required care and supervision of the Clients with less than 6 staff. During an interview on 06/24/2022 at 2:48 PM, Staff S, AC Manager, when asked how 4 staff could meet the needs of all the Clients at the house, stated that Clients 3 and 15 were pretty independent but would have to wait if they needed any assistance from staff. When asked if the facility had a contingency plan for having less than the required number of staff, Staff S stated there wasn't one. During an interview on 06/28/2022 at 4:24 PM, Staff C, Superintendent, stated that the facility had an emergent staffing plan that would be...</td>
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<td>W 195</td>
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This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021, KFRI12 Revisit Survey on 07/14/2021, and KFRI13 Revisit survey on 04/12/2022.

Findings included ...

Observation, record review, and interview, showed the facility failed to provide 3 of 6 Sample Clients (Clients 2, 3, and 4) and 1 Expanded Sample Client (Client 8) aggressive active treatment to meet their identified needs. Clients who refused to participate in active treatment did not have the reason for refusals assessed and addressed. Clients' programs were written as skill acquisition plans when the Client knew the skill but refused to do it. The amount of training programs were not sufficient to fill the Clients' days. Clients' identified needs were not addressed and there was a lack of informal training. Adult Training Program (ATP) did not have training identified to teach vocational skills and documented positively on a program if the Client showed up for even a few minutes. Refer to W196 for more details.

Record review and interview showed Client 1's hearing was not assessed. Refer to W210 for more details.

Observation, record review, and interview showed staff did not identify and assess Client 8's inappropriate behavior. Refer to W214 for more details.

Record review and interview showed clear...
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<td>W 195</td>
<td>Continued From page 30 instructions were not provided in training programs designed to teach Client 1. Refer to W234 for more details.</td>
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<td>W 196</td>
<td>ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide 3 of 6 Sample Clients (Clients 2, 3, and 4) and 1</td>
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Expanded Sample Client (Client 8) aggressive active treatment to meet their identified needs. Clients who refused to participate in active treatment did not have the reason for refusals assessed and addressed. Clients' programs were written as skill acquisition plans when the Client knew the skill but refused to do it. The amount of training programs were not sufficient to fill the Clients' days. Clients' identified needs were not addressed and there was a lack of informal training. Adult Training Program (ATP) did not have training identified to teach vocational skills. These failures prevented the Clients from having their identified needs addressed with training that would increase their independence and actively prepare them for living in a less restrictive setting.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021, KFRI12 Revisit Survey on 07/14/2021, and KFRI13 Revisit survey on 04/12/2022.

Findings included ...

Client 2

Observation at Buckley house on Wednesday, 06/15/2022 at 11:26 AM showed Client 2 carried a pitcher from the kitchen to the dining room, sat at a table, and poured themselves a glass of water. At 11:29 AM, Client 2 used the water pitcher to fill a reusable water bottle. At 11:40 AM, Client 2 asked if they could walk to work and was told to wait five minutes. At 11:45 AM, Client 2 left the house by themselves.

Record review of the facility Adult Training Program (ATP) schedule, updated 06/01/2022, showed Client 2 was scheduled for training at the...
Continued From page 32 facility greenhouse on Tuesdays, Wednesdays, and Thursdays from 12:00 PM-1:30 PM.

Record review of Client 2's ATP Monthly Program Record dated June 2022, showed that of six opportunities to attend training, Client 2 attended three times between June 1-15, 2022. The purpose of attending the training was to learn vocational training while working with plants. The training program listed the training objective as writing their day's wages on their work ledger. There was no evidence of what vocational training Client 2 was to receive during their 1 ½ hour long training sessions they were scheduled to attend three times a week.

Record review of Client 2's Qualified Intellectual Disabilities Professional (QIDP-staff responsible for the development of training program, monitoring the programs, revising the programs, training staff about the programs, and general oversight of Client training at the facility) Review, dated 06/03/2022, for the month of May 2022, showed that Client 2 attended ATP five of the twelve days the training was available in May 2022. The review did not identify attendance as a concern and did not assess or address the Client's poor attendance at the facility training program.

Record review of a facility document titled, "ICF Intermediate Care Facility (ICF)- a specialized program that provides training for Individuals with Intellectual Disability to increase their independence with the goal of moving to a less restrictive setting Active Treatment Assessment Tool", undated, showed that the facility identified that Client 2 avoided tasks by sitting in their room. The plan to address the lack of participation was
Continued From page 33

to have Client 2 meet with a facility psychologist weekly "...in the hopes of increasing their participation."

Observation at Buckley House on 06/16/2022 at 6:28 AM showed Client 2 sat in a recliner in the TV room. At 6:48 AM Client 2 spoke to State Surveyor 1 about a home visit where they would get to see their nieces. At 6:52 AM Client 2 went into the dining room, got a package of cereal, a bowl, a container of milk, and took it to a dining room table. Client 2 then opened the box of cereal, poured it into the bowl, poured milk on the cereal, then ate the cereal. At 6:54 AM, Client 2 asked Client 3 how they were doing, and Client 3 responded they were busy getting ready for work. Client 2 apologized to Client 3. At 7:54 AM, Client 2 exited a bathroom and entered their bedroom. Client 2 stayed in their room until 8:31 AM, there was no staff interaction with Client 2 while they were in their room. Client 2 was still wearing their pajamas when they exited their room. At 8:40 AM, Client 2 stated that they were going to go get ready for work and stood up. Client 2 then stated, "Please don't come in on me. It is rude." and went back into their room. Client 2 went into a bathroom for three minutes then returned to their bedroom. Client 2 was still in their bedroom when the observation ended at 8:52 AM.

Observation at Buckley House on 06/17/2022 at 6:52 AM showed Client 2 put bottles of catsup on the dining room tables. At 6:57 AM, Client 2 asked Client 3 if it was ok for Client 2 to eat. Client 3 stated that they were not responsible for Client 2. At 7:06 AM Client 2 stated, "I know how to eat." and, "I'm taking my time." to Staff P, Attendant Counselor (AC). At 7:14 AM Client 11
W 196 Continued From page 34

took their dishes to the kitchen and put them in
the sink. Staff P, asked Client 11 if they were
going to wash their dishes and Client 11 walked
past Staff P, into the TV room. At 7:15 AM, Staff
P asked Client 2 to make soapy water to wash
dishes. At 7:16 AM, Staff Q, AC, began washing
dishes and Client 2 stated, "I was going to wash
my own dishes, but whatever." Staff Q stated that
they were washing Client 11's dishes and Client 2
stated that they would wash Client 11's dishes
with their own. Client 2 independently washed,
rinsed, and put the dishes in a rack by the sink. At
7:32 AM, Client 2 sat in a recliner in the TV room.
At 7:47 AM Client 2 began talking about leaving
for a visit to their parent's home between 9:00
AM-10:00 AM that day. Client 2 stated that they
were excited to teach their niece how to play a
handheld videogame. When State Surveyor 1
asked Client 2 what they had planned for the
morning Client 2 stated that they weren't sure. At
8:35 AM, Client 11 sat in a chair next to Client 2.
Client 2 asked Client 11 to move two different
times, stating that Client 11 coughed and had a
cold. Client 11 got up and went to sit on a couch
across the room, tucking their feet up underneath
their buttocks. Client 2 stated, "Shoes off the
couch." twice to Client 11, then stated, "Last time
they had their shoes on the couch they got
yelled at." At 8:41 AM, Client 2 spent four minutes
with Staff S, AC Manager, with a calculator and
binder balancing Client 2's money ledger. At 8:45
AM Client 2 took money to their bedroom and
went into the TV room. At 8:53 AM Client 2 got a
portable phone, dialed a number by memory, and
spoke to their father, asking where they were on
the road. Client 2 told the person on the phone to
check in at the switchboard and to pick up their
medications for the home visit. Client 2 left the
house at 9:04 AM with a backpack and a duffle
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bag and went to the switchboard area of the main administrative area to wait for their dad. During the 2 hour and 12-minute observation, the only training observed lasted 4 minutes, starting at 8:41 AM and concluding at 8:45 AM.

Record review of Client 2's Individual Habilitation Plan (IHP- a plan created by the facility that identified what training the Client required to learn to be more independent to move to a less restrictive setting), dated 04/25/2022, showed that Client 2 had recently moved to the current house (Buckley) and had some program changes. The IHP showed that Client 2 struggled with a lack of participation, by refusing to complete programs that they had the skills to complete. The IHP identified that Client 2 was able to brush their teeth by themselves but needed reminders to do so, was able to complete all personal hygiene by themselves, make their own food, dress themselves, do laundry, wash dishes, use a dishwasher, and take out garbage by themselves.

Record review of Client 2's program teaching plan #1097, dated June 2022, showed that Client 2 would brush their teeth 80% of the time for 5 out of 6 months and the training was scheduled to be implemented twice a day once after lunch and once after dinner. To start the training staff were instructed to say, "Client 2's first name, brush your teeth." Of the 13 times staff documented the training, Client 2 participated five times, the other 8 times staff documented that Client 2 did not brush their teeth when staff directed them to. Staff were to document a (+) if Client 2 brushed all of their teeth and a (-) if they did not. The program did not identify what staff should do or document if Client 2 chose not to brush their teeth.
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| W 196 | Continued From page 36 when told to by staff. Record review of Client 2's IHP Revision, dated 05/26/2022, showed the facility completed the ICF tool and Client 2's team agreed that Client 2 did not have any barriers to participating in aggressive active treatment so the Client's plans would not change. Record review of Client 2's AC assessment, dated 02/19/2022, showed that if staff gestured for Client 2 to mop or vacuum a floor, they could do so. Record review of Client 2's program teaching plan #1119.1, dated June 2022, showed, "With up to two verbal cues, [Client 2's first name] will mop their room for 24 out of 36 data sessions." The plan was to be implemented three times a week and staff were to tell Client 2 to mop their room to start the training program. Of the six times staff documented the training results, Client 2 completed the task two times between June 1-15, 2022, and did not the other four times. Staff were to document a (+) if Client 2 mopped their room with 2 or less verbal cues from staff and a (-) if Client 2 did not mop their floor with 2 or less verbal cues. The program did not identify what staff should do or document if Client 2 refused to mop their floor. Record review of Client 2's program teaching plan #1133.1, dated June 2022, showed, "With up to two verbal cues, [Client 2's first name] will Vacuum their room for 24 out of 36 data sessions." The program was to be implemented three times a week and staff were to tell Client 2 to vacuum their room to start the training program. Of the six times staff documented the

This document was prepared by Residential Care Services for the Locator website.
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
RAINIER SCHOOL PAT C

#### Street Address, City, State, Zip Code
RYAN ROAD
BUCKLEY, WA 98321

#### Summary Statement of Deficiencies

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<tr>
<td>W 196</td>
<td>Continued From page 37 training results, Client 2 completed the task two times, did not complete it two times, and refused one time between June 1-15, 2022. Staff were to document a (+) if Client 2 vacuumed their floor with 2 or less verbal cues and a (-) if Client 2 did not vacuum their floor after 2 or less verbal cues. The program did not identify what staff should do or document if Client 2 refused to vacuum their floor. Record review of Client 2’s program teaching plan #1159.1, dated June 2022, showed staff would verbally cue Client 2 up to three times to balance their petty cash ledger. The program was to be implemented three times a week. Of the six times staff documented training results, Client 2 did not complete the training 5 of the 6 times as directed by staff. Staff were to document a (+) if Client 2 balanced their ledger with 3 verbal cues or less and a (-) if Client 2 did not balance their ledger with 3 verbal cues or less. The program did not identify what staff should do or document if Client 2 refused to balance their ledger. Record review of Client 2’s program teaching plan #1024.1, dated June 2022, showed that after staff provided the verbal cue of &quot;Client 2’s first name it is time to go for your 15-minute walk.&quot; to Client 2 the Client would go on a 15-minute walk. Of the 13 times staff documented training results, staff documented that Client 2 did not go for a walk 8 times. Staff were to document a (+) if Client 2 went for a 15-minute walk after staff provided a verbal cue and (-) if Client 2 did not go for a 15-minute walk after staff provided a verbal cue. The program did not identify what staff should do or document if Client 2 refused to go for a walk.</td>
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Record review of Client 2's AC assessment, dated 02/19/2022, showed Client 2 could handle dirty laundry, use the washer and dryer, and hang up/fold their own clothes by themselves.

Record review of Client 2's program teaching plan #1136, dated June 2022, showed Client 2 would wash their laundry when staff cued them to. Of the four times staff documented training results, Client 2 completed it three times. Staff were to document a (+) if Client 2 washed their laundry when cued by staff and a (-) if Client 2 did not wash their laundry when cued by staff. The program did not identify what staff should do or document if Client 2 chose not to do their laundry when told to by staff.

Record review of Client 2's program teaching plan #1136, dated June 2022, showed Client 2 would dry their laundry when staff cued them to. Of the four times staff documented training results, Client 2 completed it three times.

Record review of Client 2's AC Assessment, dated 02/19/2022, showed Client 2 needed staff to assist them with making their bed.

Record review of Client 2's program teaching plan #1120.1, dated June 2022, showed that Client 2 was supposed to change their bedsheets twice a week on Monday and Friday. To start the training, staff were to tell Client 2 to change the sheets on their bed and point to the bed. Of the four times staff documented training results, Client 2 completed it one time. The teaching method showed that if Client 2 placed the fitted sheet and the top sheet on the bed after removing the dirty sheets, they would get a (+) sign showing they did the activity. If Client 2 did
**NAME OF PROVIDER OR SUPPLIER**
RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE**
RYAN ROAD
BUCKLEY, WA 98321

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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- The program did not identify what steps of fitting the sheet on the bed that the Client might need help with or what staff should do or document if Client 2 chose not to change their sheets when told to by staff.
- Record review of Client 2's program teaching plan #1019.1, dated June 2022, showed Client was to make an entrée of their choice once daily. Staff were to cue Client 2 to choose an entry from a list provided. Of the 12 times staff documented training results, Client 2 completed it six times. Staff were to document a (+) if Client 2 made an entrée with 3 or less verbal cues and a (-) if Client 2 did not make the entrée with 3 or less verbal cues. The training plan did not identify what staff should say or do if the Client chose to eat the food provided to the house from the facility kitchen, instead of making their own food as the program directed.
- During an interview on 06/24/2022 at 11:30 AM, Staff S, ACM, Staff U, Developmental Disabilities Administrator (DDA) 1, Staff V, DDA 1, Staff W, QIDP, and Staff X, Psychology Associate, verified that Client 2's IHP was current and training programs #1097, #1119.1, #1133.1, #1159.1, #1024.1, #1136, and #1019.1 for Client 2 were current. When asked if Client 2's teaching programs addressed their refusal to complete tasks they already had the skills for, they replied that Client 2's toothbrushing program was intended to get the Client into a routine of brushing their teeth. When asked if the facility had assessed the reason the Client did not want to participate in training programs, they stated that Client 2 was meeting with Staff AA, Psychologist, with the hopes of increasing Client...
### Summary Statement of Deficiencies

#### W 196

Continued From page 40

2's participation in training programs.

Client 3

Observation at Buckley House on 06/15/2022 at 12:26 PM showed Client 3 entered the dining room, put disposable gloves on both hands, got dishes and served themselves food, then went to a table to eat. As Client 3 was eating they stated, "I cleaned the windows."

Observation at Buckley House on 06/16/2022 at 6:34 AM showed Client 3 in a bathroom applying makeup. At 6:50 AM Client 3 entered the dining room got a bowl, cereal, and milk, then prepared and ate the cereal. At 6:57 AM Client 3 took their dish to the kitchen and washed it without staff telling them to. At 7:24 AM Client 3 and staff left the house.

Observation at Buckley House on 06/17/2022 at 6:55 AM showed Client 3 setting up the serving area for breakfast. Client 3 stated that they had to eat because they had to leave for work.

Record review of Client 3's IHP Revision, dated 06/10/2022, showed Client 3 was able to provide their own oral hygiene but needed encouragement to do a "good" job.

Record review of Client 3's training program #1097.3, dated 06/06/2022, showed that when staff provided the verbal cue, "Client 3's first name, brush your teeth." if Client 3 brushed their teeth staff would document a (+) and if Client 3 did not brush their teeth after staff verbally cued them to, staff would document a (-). Of the 13 times staff documented the training results, Client 3 received a (+) 10 times and a (-) 3 times. The
Continued From page 41

Program plan indicated that Client 3 was independent and if they chose not to participate staff were to ask them what time they would like to complete the training. Staff would remind Client 3 of the chosen time and explain that they chose this time to complete the training. There were no instructions for what staff were to do or how to document if Client 3 refused to pick a time and did not brush their teeth.

During an interview on 06/24/2022 at 11:30 AM, Staff B, Program Area Team Director, stated that Client 3’s program was not about learning how to brush their teeth, it was about being compliant with brushing their teeth. When asked what Client 3 was learning, Staff B stated that Client 3 would refuse to brush their teeth so staff would ask the Client to brush their teeth so they would get into the habit of brushing their teeth twice a day.

Record review of Client 3’s IHP, dated 01/11/2022, showed Client 3 wanted to maintain their ability to balance their ledger and was able to do so by themselves but may need reminders to do so.

Record review of Client 3’s training program #1159, dated June 2022, showed that after staff cued Client 3 to deduct the amount of a purchase from their ledger, staff would document a (+) if Client 3 maintained the ledger and a (-) if they did not. Of the 9 times staff documented the training results from June 1-13, 2022, staff documented three (+) and six (-). The program indicated that Client 3 was independent but did not provide instructions for staff on how to encourage Client 3 to participate in the training plan.

Record review of Client 3’s Intermediate Care Program plan indicated that Client 3 was independent and if they chose not to participate staff were to ask them what time they would like to complete the training. Staff would remind Client 3 of the chosen time and explain that they chose this time to complete the training. There were no instructions for what staff were to do or how to document if Client 3 refused to pick a time and did not brush their teeth.

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Facility (ICF) Active Treatment Assessment Tool (an ICF is a specialized facility to provide training to Clients with intellectual disabilities to increase their independence so they can live in a less restrictive environment), undated, showed Client 3 had shown a lack of interest in participating in a program if the Client felt that they already had the skill.

Record review of Client 3’s training program #2148, dated June 2022, showed that with a verbal cue from staff, Client 3 would engage in a social interaction lesson from their workbook 70% of the time for 5 of 6 months. Of the 25 times staff documented between June 1-15, 2022, Client 3 did not participate, staff were to ask them again in an hour. The program did not provide staff with what to do, or how to document if Client 3 refused to do the training program at the end of the hour.

Record review of Client 3’s training program #4015.1, undated, showed with a verbal cue from staff, Client 3 would select an activity to participate in with staff 90% of the time for 5 out of 6 months. Staff were to cue Client 3 to pick an activity to participate in. The program showed that Client 3 was independent, had good communication, reading, and writing skills, and could follow instructions from games. If Client 3 chose not to participate in training, staff were to ask them what time they would like to complete the training program and follow up at that time. Staff were to remind Client 3 that they chose the time to complete the training program at that time.

During an interview on 06/24/2022 at 11:30 AM with Staff S, ACM, Staff U, DDA 1, Staff V, DDA
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

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**Multiple Construction**

- **Address:** 50G047
- **State:** WA
- **City:** BUCKLEY
- **Zip Code:** 98321

**Date Survey Completed:** 07/14/2022

**Provider's Plan of Correction**

_Each corrective action should be cross-referenced to the appropriate deficiency._

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**Summary Statement of Deficiencies**

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

**Client 3**

1. Staff W, QIDP, and Staff X, Psychology Associate, when asked if Client 3's lack of interest in participating in training programs was being addressed, they stated that Client 3 was meeting weekly with Staff AA, Psychologist, to learn coping skills, interaction skills and social stories.

**Client 4**

Record review of Client 4's AC Assessment, dated 04/14/2022, showed that they needed partial physical assistance to make their bed, shave thoroughly, and clean their CPAP (machine used to help a person breathe properly while sleeping). Client 4 needed full physical assistance to wash and dry their back, file and trim their nails, and apply first aid. It showed they did not maintain a personal account ledger or use a debit card.

Record review of Client 4's Individual Habilitation Plan (IHP), dated 05/05/2022, showed that they required minimal supervision, no longer benefitted from skilled training, refused to participate in active treatment, and they would benefit from living in a place where active treatment was not a priority. It showed that Client 4's participation level in activities was based on their mood. Client 4 required staff assistance to wash and dry their lower extremities and back. Client 4 needed cues to apply deodorant, and full physical assistance to trim their beard. Client 4 struggled with putting on socks and shoes. Client 4 refused to attend dental and other medical appointments.

Record review of an IHP Revision for Client 4,
Continued from page 44 dated 05/16/2022, showed the facility identified a need for training related to the use of fasteners when dressing, utensil usage, food preparation, grooming, and domestic skills.

Record review of an IHP Revision for Client 4, dated 05/24/2022, showed that they no longer benefitted from living in a training facility and was hard to engage in active treatment to address their identified needs. The Revision did not address the Client's lack of participation in active treatment.

Record review of Client 4's formal training programs showed there were no programs to address the identified needs to learn to use fasteners, use utensils when eating, prepare food, make their bed, clean their CPAP machine, maintain a personal ledger account, use a debit card. There were no formal programs for the maintenance of skills to check in with staff, independently make an appointment, make an alternate meal, and independently complete household chores per the IHP Revision 05/24/2022.

Record review of Client 4's ICF Active Treatment Assessment Tool, undated, showed that Client 4's skill level in training was dependent upon their cooperation and mood along with whether they liked the staff who asked them to complete a task. Client 4 had an overall lack of interest in training, had reached an age where training was no longer a priority, and would benefit from living in a slower paced environment where training was not a priority.

Record review of Client 4's Active Treatment Schedule, updated 06/01/2022 showed there...
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<td>were &quot;informal objectives/skills to be maintained&quot; to be implemented throughout the day with no staff instructions attached or reference found in Client 4's IHP, dated 05/05/2022. There was no description for how staff were to approach Client 4, what they were to say, how they were to say it, and how to redirect them if needed when providing encouragement.</td>
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Observation on 06/16/2022 at 7:24 AM in Devenish House showed Client 4 was in the dining room. Staff T, Attendant Counselor, served breakfast. After asking Client 4 if they wanted hard boiled eggs and toast, Staff T placed the eggs, a small carton of milk, and a carton of yogurt on a plate and carried it into the kitchen without Client 4 doing this themselves. Client 4 self-propelled their wheelchair with their feet into the kitchen. Staff T got the bread from a shelf and removed 2 slices of bread and handed them to Client 4 who placed them in the toaster and pushed down the lever. At 7:29 AM, Staff T popped the toast up and put peanut butter on a knife and handed it to Client 4 who then spread it on the toast. Client 4 then used their feet to self-propel into the dining room and up to a table. Staff T carried Client 4's plate of food to the table and set it in front of them. Client 4 made an egg sandwich that they proceeded to eat and opened the carton of milk and drank it. At 7:37 AM, Client 4 asked for a rag. Staff T brought them one and did not ask them to get it themselves. At 7:45 AM, Staff T told Client 4 that they would carry their plate to the garbage, but they (Client 4) needed to throw it away. Staff T did not cue Client 4 to take their own plate to the garbage themselves. Client 4 self-propelled to the trash can using their feet, took the plate from Staff T, threw the trash away, and took their plate to the sink. Staff T handed.
Client 4 the scrub brush and held the plate while Client 4 washed it. Staff T then placed it in a rack for the sanitizer. Client 4 followed Staff T around the house until the observation ended at 7:57 AM. No training was observed during this 33-minute observation and the staff did tasks for them, instead of encouraging them to do it themselves.

Observation on 06/21/2022 at 12:31 PM in Devenish House showed Client 4 sat in their wheelchair in the back hallway on the B side of the house. From 12:38 PM - 12:55 PM, Staff T gave $2.00 to Client 4 and had the Client sign a piece of paper that they received that amount of money. Client 4 and Staff T then had a conversation about spending the $2.00 and being mindful of their diet. No training was observed during this 17-minute observation.

Observation on 06/21/2022 at 1:03 PM - 1:47 PM showed that Client 4 and Staff T left the Coffee Shop and went for a walk in the Administration Building, returned to Devenish House where Client 4 refused to participate in activities offered by Staff T, visited a staff in Hyak House, returned to Devenish House, sat in the back hallway in their wheelchair, and made inappropriate remarks using profanity in a low quiet voice. No training was observed during this 44-minute observation.

Observation on 06/21/2022 at 1:53 PM - 2:21 PM in Devenish House showed Staff T tried to engage Client 4 with no response. Client 4 followed Staff T through the house, refused to engage in activities offered by Staff T, sat in the living room and back hallway next to the bathroom, got a plastic glass from their bedroom, got water within the bathroom twice, refused to engage in a conversation with Staff T, got water within the bathroom twice, refused to engage in conversations with Staff T, sat in the living room and back hallway next to the bathroom, got a plastic glass from their bedroom, got water within the bathroom twice, refused to engage in conversations with Staff T.

Observation on 06/21/2022 at 10:03 PM - 10:47 PM showed that Client 4 and Staff T left the Coffee Shop and went for a walk in the Administration Building, returned to Devenish House where Client 4 refused to participate in activities offered by Staff T, visited a staff in Hyak House, returned to Devenish House, sat in the back hallway in their wheelchair, made inappropriate remarks using profanity in a low quiet voice. No training was observed during this 44-minute observation.
### Summary Statement of Deficiencies

(W 196) Continued From page 47

**Observation on 06/21/2022 at 2:26 PM in Devenish House showed Client 4 went with Staff T to the kitchen and then to the manager's office.**

At 2:31 PM Client 4 exited the manager's office, went into the bathroom, and sat in the hallway outside the bathroom door. At 2:43 PM Client 4 went back into the manager's office and spoke with an angry but unintelligible voice when they saw State Surveyor 2. Staff O, Attendant Counselor Manager, entered their office and asked Client 4 if they were having a hard time, then told them they were "doing real good on their programs." At 2:47 PM Client 4 left the manager's office, went into the bathroom, then sat in the hallway. At 2:54 PM the nurse arrived and proceeded to dispense Client 4's medications. The nurse did not implement Client 4's self-administration of medication program.

From 3:03 PM - 3:18 PM Client 4 sat in their wheelchair on the B side of the house. No training was observed during this 52-minute observation.

Observation on 06/21/2022 from 3:18 PM - 3:28 PM in Devenish House showed Client 4 was in Staff CC's office talking with them. At 3:28 PM, Client 4 sat in the hallway outside the bathroom door. At 3:37 PM, Client 4 went into the bathroom. At 3:39 PM, Staff CC left their office and closed the bathroom door. At 3:42 PM Client 4 exited the bathroom and sat in the hallway. From 3:51 PM - 3:56 PM Client 4 was in Staff CC's office. From 3:56 PM - 3:58 PM, Client 4 sat in the hallway. No training was observed during this 40-minute observation.
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

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#### NAME OF PROVIDER OR SUPPLIER

RAINIER SCHOOL PAT C

#### STREET ADDRESS, CITY, STATE, ZIP CODE

RYAN ROAD  
BUCKLEY, WA  98321

### Statement of Deficiencies and Plan of Correction

**Possible Deficiencies:

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<tr>
<td>W 196</td>
<td>Continued From page 48 Observation on 06/21/2022 at 3:56 PM in Devenish House showed Client 4 sat in the hallway. At 3:58 PM Client 4 went into the front room on B side and talked to Staff EE, AC, about the air conditioning and keeping the doors and windows closed. Client 4 followed Staff EE to the A side of the house into the kitchen. Client 4 asked Staff EE what was for dinner. At 4:07 PM Client 4 went into the dining room, looked in drawers, took a plate, went into the kitchen and sat there. At 4:11 PM Client 4 opened the refrigerator and looked in it. Staff O entered the kitchen and asked, &quot;Snacking?&quot; At 4:15 PM Client 4 talked to an AC staff about a snack. The staff got some bologna and cheese for them and put it on their plate, then told the Client that they will get them some bread. While the AC staff was gone from the kitchen, Client 4 opened the freezer door then stood and got something from it. At 4:19 PM, the AC staff returned. Client 4 said, &quot;No bread.&quot; The AC staff said they knew that, put on gloves, got two slices of bread, and made the sandwich while Client 4 remained sitting in the kitchen in their wheelchair. At 4:22 PM Client 4 took their sandwich on the plate and a drink to the B side living room. Client 4 transferred themselves into a recliner after putting the plate and cup on a table beside it. They ate their snack. At 4:29 PM Staff O entered the room and asked them if they wanted to watch television and turned it on for them. From 4:29 PM - 5:15 PM Client 4 sat in the living room watching television, went to the bathroom twice, sat in the hallway outside their bedroom door, then returned to the living room. No training was observed during this 1 hour and 19 minutes. Observation on 06/22/2022 at 9:42 AM in Devenish House showed an AC staff asked Client</td>
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<td>4 if they wanted to watch a movie. Client 4 said, &quot;F<strong>k you racial slur. F</strong>k you too.&quot; Then repeated louder, &quot;F<strong>k you too.&quot; A staff entered the house and walked by Client 4 and said good morning to them. Client 4 yelled, &quot;F</strong>k you racial slur.&quot; repeatedly at the staff. The staff walked away, and no other staff responded to Client 4’s remarks. Client 4 went to the front door. A staff asked them if they wanted the staff to get their shoes for them. Client 4 yelled, &quot;F**k you racial slur. I will do it myself.&quot; and went outside the house. Record review of Client 4’s PBSP, dated 06/01/2022, showed when Client 3 engaged in verbal aggression, staff were to remain calm and tell them that how they were talking was not appropriate, that it was okay to be upset, and yelling at others was not okay. Then staff were to problem solve and try to determine what was wrong. This did not occur. During an interview on 06/23/2022 at 9:44 AM, Staff CC, QIDP, Staff GG, Psychology Associate, and Staff V, DDA1, stated that the facility identified Client 4 for community placement, and their plan was to help them gain skills to transition to the community and maintain their skills. Staff CC stated that they did not see Client 4 participate consistently in active treatment. Staff V stated that they did not want to try and run programs with Client 4 when they were upset or agitated. Staff GG stated that Client 4 helped out when they wanted to with the right encouragement and the right person. Client 8 Observation on 06/21/2022 at 1:34 PM at the</td>
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Continued From page 50

facility campus showed Client 8 crossed 2nd Avenue (a street that is part of a large facility campus and used by cars) at a crosswalk without pausing. Client 8 was by themselves.

Observation on 06/21/2022 at 2:10 PM at the facility campus showed Client 8 walked from the administrative building to the gym by themself. Construction was occurring in front of the gym and the sidewalk was blocked by safety cones. At 2:15 PM, Client 8 stood, staring at the cones. At 2:17 PM Client 8 cautiously moved their right foot off of the curb onto a grate in the street. Client 8 flinched and pulled their foot back onto the sidewalk. Client 8 then cautiously put their left foot onto the street and stepped off of the curb. Client 8 walked down the middle of the street for two minutes. At 2:19 PM Client 8 walked to an open parking spot in front of the canteen and went up onto the sidewalk. At 2:20 PM Client 8 turned back towards the front of the campus, crossed the street without pausing, and resumed walking in the middle of the street. A blue jeep came up behind Client 8 and then went around the Client. At 2:23 PM Client 8 stepped back up on the sidewalk near the gym. A staff in a car stopped and told Client 8 to get out of the sun and then drove off. At 2:26 PM, Client 8 entered the main administrative building, walked through the waiting area, then exited through the back door. At 2:29 PM Client 8 went down the covered walkway, turned left at a road and began walking in the street, not using the sidewalk.

Observation on 06/21/2022 at 3:56 PM showed Client 8 walked, by themselves, in the street in front of Buckley House. Staff Y, ACM walked up to Client 8 and asked them if they needed to learn to walk on the sidewalk. Client 8 continued
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**Continued From page 51**

walking on the street toward Haddon House and entered at 3:59 PM.

Observation on 06/21/2022 at 5:53 PM showed Client 8 walked, by themselves, in the street in front of Buckley House instead of using the sidewalk.

Record review of Client 8's IHP, dated 08/03/2021, showed Client 8 could go anywhere on campus by themselves. Client 8 had specific staff they preferred, they did not like to be directed to do things, and the Client was resistive to learning new skills. In April 2021 staff noticed that Client 8 was having difficulty seeing the remote control for the TV. Client 8 was diagnosed with a chronic eye condition and had little to no vision in their right eye, the facility was concerned with the vision in their left eye, and the facility identified that Client 8 was anxious about losing their vision. The IHP identified that Client 8 was independent with toileting, bathing (with reminders), was capable of brushing their own teeth but did not do a thorough job, was not always consistent or thorough with completing personal hygiene, could serve food by themselves, eat independently, and take their dishes to the kitchen independently. Client 8 required reminders to wear clean clothes, needed reminders and some staff assistance with clipping and managing their fingernails and toenails, and was able to independently complete many household tasks.

Record review of Client 8's Attendant Counselor Assessment, dated 07/26/2022 and updated 04/18/2022, showed that Client 8's refusals to help prepare meals and snacks had increased, Client 8 could dress themselves, would spill...
W 196 Continued From page 52

beverages when pouring, required staff to cue them to comb/brush their hair but could otherwise shower by themselves, required verbal cues to complete all of the steps of brushing their teeth (the section indicated that Client 8 was very independent with activities of daily living but needed to be reminded to brush their teeth), required verbal cues to make their bed, clean the bathroom, mop, vacuum, use and empty garbage cans, and wipe/dust surfaces. The assessment showed that Client 8 would clean up after themselves when asked by staff, refused to use a magnifier glass to read, did not want to learn how to use a sharp knife, refused further training around budgeting, was not interested in opening their own mail and did not want to participate, and was able to keep themselves busy. The recommendations were to learn to do laundry, brush their teeth without staff cueing them, dialing a phone with large numbers, and a program for the mail procedure which the Client refused.

Record review of Client 8’s formal teaching plans showed the following programs-

#1097-When provided a verbal cue and staff gesture, Client 8 would thoroughly brush the upper left quadrant of teeth with 90% or greater accuracy of data sessions. The training was started on 06/02/2022.

#1149- When Client 8 called the house, they would tell staff where they were. The training was based on the Client calling the house by themselves. The criteria for ensuring Client 8 knew the skill was they would tell staff where they were 75% or more for 5 of 6 consecutive months.

Record review of Client 8’s service care plan
Continued From page 53 #8052, dated 06/01/2022, showed, "They frequently leaves their house for long periods, therefore, their meds are centered around when they are actually at the house, generally at mealtimes."

Record review of Client 8's IHP, dated 06/03/2021, showed they liked to spend as much time as possible out of the house and typically left Haddon House around 8:00 AM.

Record review of Client 8's Active Treatment Schedule, dated 06/06/2022, showed from 8:00 AM-9:30 AM staff should provide informal training and skill maintenance for socialization, exercise, communication, and pedestrian safety. From 9:30 AM-11:00 AM Client 8 was scheduled for Adult Training Programs.

Observation on 06/22/2022 at 9:28 AM showed Client 16 and Staff DD, Adult Training Staff, in Columbia house. Two binders sat on the table, one with Client 8's name on it. At 9:32 AM, Staff DD answered a phone and stated, "I haven't seen them yet." At 9:34 AM, Staff DD stated, "They rarely comes in with everybody else." and "I wouldn't be surprised if they shows up in the next 10 minutes." Staff DD stated that the house called asking if Client 8 had arrived. Staff DD and Client 16 completed several puzzles until 9:51 AM when Staff DD stated that they would need to find out where Client 8 was and made a phone call. While on the phone, Staff DD stated that they would document that Client 8 was remaining at the house that day.

During an interview on 06/22/2022 at 9:52 AM, when asked how long Client 8 needed to be in training in order to get credit for attendance, Staff
Continued From page 54

DD stated, "At least 15 minutes. They go by their own drummer, not interested in programs. Not a lot of progress in programs. Will just plug their ears and ignore me."

Observation at Columbia House on 06/22/2022 at 9:55 AM showed Client 8 walked up to the front door of the training house and entered. Staff DD stated that Client 8 being late to training was usual. Client 8 removed their coat and then sat at the table across from Staff DD. At 10:00 AM, Staff DD placed four cards in front of Client 8 and asked if the Client could find the picture of a policeman. Client 8 responded by singing "Jingle bells" and stated that Client 10 was a "b*tch." Staff DD did not respond or attempt to redirect Client 8's inappropriate comment. From 10:00 AM-10:26 AM, Staff DD attempted to engage Client 8 in activity, Client 8 sang, plugged their ears with their fingers, or spoke to themselves and did not engage with Staff DD. At 10:26 AM, Staff DD asked Client 8 what they did at 10:30 AM and Client 8 stood up. Staff DD stated that it wasn't 10:30 AM and Client 8 sat back down. At 10:30 AM, Staff DD stated, "It is 10:30, let's go." Client 8 followed Staff DD and Client 16 out of the training area. Staff DD and Client 16 walked ahead of Client 8. They stopped at a crosswalk and Staff DD spoke to Client 16 about looking both ways and then crossed the street. Client 8 was approximately 10 feet behind them and crossed the street without pausing. At 10:37 AM, Staff DD and Client 16 stopped at another crosswalk, Client 8 was approximately 15 feet behind them. Staff DD repeated the instructions to Client 16, and they crossed the street. Staff DD did not attempt to speak to Client 8, and Client 8 crossed the street without pausing. The same situation occurred at 10:40 AM and 10:42 AM. At
Continued From page 55

10:45 AM, Staff DD and Client 16 arrived at the main covered walkway in the middle of the campus. Staff DD stated that Client 8 had "run of the grounds" and that Client 8 usually left the group at that point. Staff DD and Client 16 turned left towards the houses and Client 8 turned right towards the main administration building. No training occurred during this observation period.

During an interview on 06/22/2022 at 10:45 AM, when asked if Client 8 had a typical day that day, Staff DD stated, "Yeah."

Observation of Client 8 on 06/22/2022 at 10:45 AM showed Client 8 entered the main administrative building and went into a bathroom. After exiting they went to the switchboard and then left, going down the covered walkway toward the houses. Client 8 went to the road in front of Buckley House, turned back and walked up the covered walkway to the building across from the main administrative building, opened the door and started to enter then turned and walked back down the covered walkway. At 10:54 AM, Client 8 walked in the street in front of Buckley House and went to Haddon House walking in the middle of the road. Client 8 entered Haddon House at 10:55 AM and went to their room. During the one-hour observation no training was observed.

During an interview on 06/24/2022 at 1:00 PM with Staff U, DDA 1, Staff V, DDA 1, Staff Y, ACM, and Staff B, Program Area Team Director, stated that Client 8's IHP and training programs were current. When asked how the two formal plans Client 8 had addressed their training needs, they stated that Client 8 has the skill to do things but did not demonstrate the skill. They stated that three additional maintenance programs were
### W 196
Continued From page 56

Recently added. When asked how Client 8's ATS provided staff with information on informal training opportunities they stated that communication while visiting staff and pedestrian safety skills were informal trainings more would be included when the facility completed the Client's new IHP. They also stated that they had requested a meeting with the other QIDPs to discuss additional training opportunities and the Client's IHP was scheduled for the end of June. They stated that they were not "pushing" as hard as they could and implementing a Plan of Correction (a plan the facility implements to fix deficient practice that was identified during a prior survey) takes time, so they implemented maintenance programs as a result.

### W 210
INDIVIDUAL PROGRAM PLAN

Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a hearing assessment for 1 of 6 Sample Clients (Client 1) within 30 days of admission to the facility. This failure prevented the facility from being able to identify and address any possible hearing needs for Client 1.

Findings included ...

Record review of Client 1's Admission Healthcare
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
50G047

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
R 0/29/2022

NAME OF PROVIDER OR SUPPLIER
RAINIER SCHOOL PAT C

STREET ADDRESS, CITY, STATE, ZIP CODE
RYAN ROAD
BUCKLEY, WA  98321

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

W 210 Continued From page 57

Assessment, dated 09/22/2021, showed that they had no formal hearing testing noted, and a recommendation for evaluation by the consultant audiologist.

Review of Client 1’s file on 06/16/2022 at 8:00 AM showed there was no hearing/audiological assessment in the file.

Record review of Client 1’s current Ninety-Day Healthcare Assessment, dated 03/15/2022 and signed on 04/05/2022, showed no reference to an audiological assessment and that Client 1 had no appointments scheduled.

During an interview on 06/24/2022 at 10:30 AM, Staff FF, Qualified Intellectual Disability Professional, stated that Client 1 did not have an audiological assessment completed and they were not scheduled for one.

W 210

INDIVIDUAL PROGRAM PLAN
CFR(s): 483.440(c)(3)(iii)

The comprehensive functional assessment must identify the client’s specific developmental and behavioral management needs.

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to assess 1 Expanded Sample Client’s (Client 8) inappropriate comments about, and to, other Clients and staff. This failure resulted in Client 8 not learning how to appropriately speak about others, and placed Clients at risk for potential verbal abuse from Client 8.

W 214
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>W 214</td>
<td>Continued From page 58 Findings included ...</td>
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<td>Observation on 06/21/2022 at 1:46 PM in the waiting area of the main administrative building showed Client 8 sat in a chair. Client 8 stated a name then, &quot;They are a spastic turtle.&quot; At 1:50 PM, Client 8 stated, &quot;Client 10 first and last name is a b<em><strong>h.&quot; then mumbled and repeated, &quot;Is a b</strong></em>h.&quot; At 1:52 PM Client 8 continued speaking names and adding &quot;Is a pig&quot; after each one. At 1:53 PM, Client 8 knocked on a staff door in the administrative building and when the door opened Client 8 stated, &quot;A first name is a pig.&quot; The staff replied but State Surveyor 1 was too far away to hear, and Client 8 responded, &quot;A first name is nice.&quot; and walked back to the waiting area. At 1:54 PM, Client 8 resumed naming people and stated, &quot;Staff Z first and last name is a pig.&quot; At 2:00 PM Client 8 repeated, &quot;Staff Z first and last name is a pig.&quot; and laughed.</td>
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<td>Observation at Columbia House on 06/22/2022 at 10:00 AM showed Client 8 sat at a table across from Staff DD, Adult Training Staff. Client 8 stated, &quot;Client 10 first and last name is a b***h.&quot; Staff DD did not respond or attempt to redirect Client 8's inappropriate comment.</td>
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<td>Observation at Haddon House on 06/22/2022 at 11:05 AM showed Client 8 stated, &quot;A first name is a pig.&quot; and Client 8 smiled as they left the Attendant Counselor Manager's (ACM) office. Staff Y, ACM, did not address Client 8's inappropriate comments.</td>
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|               | Record review of Client 8's Individual Habilitation Plan (IHP—a document the facility creates that
|               | Case 3:22-cv-05651 Document 1-4 Filed 09/02/22 Page 63 of 87
Includes Client's training needs, and how the Client's needs will be addressed, dated 08/03/2021, showed that a social story would be created to address Client 8's teasing although it had been ongoing for at least 40 years. The IHP showed that Client 8 enjoyed teasing others and it was usually meant in a playful manner.

Review of Client 8's files and program book showed no social story related to saying inappropriate things while teasing.

Record review of Client 8's Psychological Assessment, dated 08/07/2021, showed Client 8 "appears to enjoy teasing others in their own unique way, in a playful and endearing manner." Client 8 was supported with a Positive Behavior Support Plan (PBSP - a document that describes inappropriate behaviors and how staff will teach a Client more appropriate behaviors) until 2016 when the team determined there were no significant socially inappropriate challenging behaviors.

During an interview on 06/22/2022 at 11:17 AM, Staff Y, ACM stated that Client 8 did not have a PBSP.

During an interview on 06/24/2022 at 1:00 PM, Staff Z, Qualified Intellectual Disability Professional, stated that they only heard Client 8 call another Client a "b***h" one time. Staff Z stated that when Client 8's environment changed they could become anxious.

Each written training program designed to

**INDIVIDUAL PROGRAM PLAN**

**CFR(s): 483.440(c)(5)(i)**
W 234
Continued From page 60

implement the objectives in the individual program plan must specify the methods to be used.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to provide clear instructions for staff to implement a training program for 1 of 6 Sample Clients (Client 1). This failure interfered with the teaching process unless staff removed their mask to follow the instruction, and placed Client 1 at risk to contract a contagious disease.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021 and the KFRI12 Revisit survey on 07/14/2021.

Findings included ...

Record review of Client 1’s Program Objective #2121.1 for June 2022 showed the objective as: Given a verbal cue paired with modeling Client 1 would make the "CH" sound before saying the rest of the word. In the teaching sequence it showed that if Client 1 made the "CH" sound incorrectly, staff were to have them try again by watching staff's mouth and form their mouth in the same way.

Record review of the Washington State Department of Health website showed that masks are required in long-term care settings as an important tool for reducing the transmission of COVID-19 (a respiratory disease caused by a virus that spreads mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, or talks) especially with the emergence of more contagious variants.
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>W 234</td>
<td>Continued From page 61</td>
<td>Record review of the Tacoma-Pierce County Health Department website showed a state requirement for people to wear masks in long-term care settings. This is to limit the transmission of droplets that could spread disease when one talks, laughs, sings, sneezes, or breathes.</td>
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<td>W 242</td>
<td>INDIVIDUAL PROGRAM PLAN</td>
<td>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</td>
<td>CFR(s): 483.440(c)(6)(iii)</td>
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This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop training for identified needs in the areas for dressing and self-feeding for 1 of 6 Sample Clients (Client 1). This failure resulted in a lack of essential training to address Client 1’s identified needs.

This is a repeat citation from KFRI13 completed 04/22/22.
### Findings included ...

Record review of an Individual Habilitation Plan (IHP) Revision for Client 1, dated 05/16/2022, showed the facility identified a need for training related to the use of fasteners when dressing, utensil usage, food preparation, grooming, and domestic skills.

Record review of Client 1’s IHP, dated 08/25/2021, showed they were admitted to the facility on 08/04/2021 for stabilization of their psychiatric medications to reduce inappropriate behaviors while receiving ongoing training to enhance their ability to live as independently as possible in the community. House programs were to address skills in areas of daily living, domestic upkeep, traffic safety, money management, and basic academics. Informal training was in the areas of mail processing, community integration, communications, health safety and maintenance, and social interactions. The IHP provided a summary of the needs identified in the Comprehensive Functional Assessment for Client 1, however there was no mention of training Client 1 to use fasteners, use utensils, teach food preparation, grooming, or domestic skills.

Record review of Client 1’s training programs showed that there were no programs for using fasteners, using utensils, or food preparation.

During an interview on 06/24/2022 at 10:30 AM, Staff U, Developmental Disabilities Administrator (DDA) 1, Staff V, DDA 1, Staff X, Psychology Associate, and Staff FF, Qualified Intellectual Disability Professional, stated that they would get to the needs identified in the 05/16/2022 IHP.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Street Address, City, State, Zip Code:** Ryan Road, Buckley, WA 98321

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID Prefix</th>
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<th>Provider's Plan of Correction</th>
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<td>W 242</td>
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<td>Continued From page 63 Revision.</td>
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<td>W 251</td>
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<td>Program Implementation CFR(s): 483.440(d)(3)</td>
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Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

This STANDARD is not met as evidenced by:

- Based on observation, record review, and interview, the facility failed to implement 1 of 1 Expanded Sample Client's (Client 7) Positive Behavior Support Plan (PBSP) when staff left them on their own in a room. This failure left Client 7 at risk for self-injury when staff did not follow their supervisions requirements. Client 7 needed to be within their assigned Staff's line of sight and Staff needed to be within arm's reach in case Client 7 they stood up or walked.

This is a repeat citation from KFRI11 Recertification survey on 05/06/2021.

Findings included ...

Observation at Buckley House on 06/17/2022 at 6:58 AM showed Client 7 alone in the B-side TV room. Staff P, Attendant Counselor, was in the dining room with three Clients and one additional staff. Client 7 was alone in the TV room until 7:09 AM when Staff P brought them to the dining room for breakfast.
W 251  Continued From page 64

Record review of Rainier School Communication Sheet, dated 06/17/2022, showed there were four staff assigned to care for the 8 Clients at Buckley House from 6:15 AM on the morning shift until additional staff arrived at 8:00 AM.

During an interview on 06/17/2022 at 6:54 AM, Staff P verified there were 4 staff assigned and present at the house at that time.

Record review of Client 7’s PBSP, dated 10/21/2021, showed that they required significant assistance from staff with line-of-sight supervision during the AM and PM shifts. The PBSP identified Client 7 had:

- self-injurious behaviors defined as hitting their head on objects, biting themselves, pulled out their own body hair, and pulled very hard on their scrotum.
- physical aggression defined as biting, hitting, scratching, pinching, kicking, spitting, and pulling on hair or clothing of others.
- property destruction defined damaged or destroying property by putting holes in walls, breaking windows, ripping bedding, towels, curtains, and clothing, and throwing things away or flushing them down a toilet.
- disruptive behaviors defined as yelling, screaming, and pounding on walls or other surfaces.
- inappropriate sexual behavior defined as placing their hands down their pants.

During an interview on 06/17/2022 at 7:20 AM, Staff P verified that Client 7 required a dedicated staff, assigned only to them, to provide line of sight supervision for the Client.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE**
RYAN ROAD
BUCKLEY, WA 98321

**SUMMARY STATEMENT OF DEFICIENCIES**

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<tr>
<th>W 261</th>
<th>PROGRAM MONITORING &amp; CHANGE</th>
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<tr>
<td>CFR(s): 483.440(f)(3)</td>
<td>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</td>
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This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to protect the rights for 1 of 6 Sample Clients (Client 1) when they restricted the number of calories and snacks they could consume each day, without due process. This failure resulted in the facility placing a restriction on Client 1 without the required quorum (the minimum number of members of an assembly or society that must be present at any of its meetings to make the proceedings of that meeting valid) from the Human Rights Committee (HRC) signing off on the consent to restrict what and how much Client 1 could eat.

Findings included ...

Record review of Rainier School Informed Consent for Client 1’s diet restriction to change their daily caloric count from 2200 to 1800 calories with one snack at 2 PM showed Client 1’s guardian signed the consent on 01/25/2022. There were two signatures representing members of the facility's HRC, dated 02/22/2022. The facility Superintendent initialed and dated the form 02/25/2022.
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<td>Record review of facility Standard Operating Procedure 1.05, &quot;Human Rights Committee,&quot; dated 08/28/2020, showed that a quorum consisted of at least three members.</td>
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<td>During an interview on 06/24/2022 at 10:30 AM, Staff FF, Qualified Intellectual Disability Professional, stated that they did not have an answer for why the consent for Client 1's diet restriction had only two HRC member signatures.</td>
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<td>W 318</td>
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<td>HEALTH CARE SERVICES CFR(s): 483.460</td>
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<td>The facility must ensure that specific health care services requirements are met.</td>
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<td>This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their health care system provided 2 of 6 Sample Clients (Client 4 and 5) and 24 Expanded Sample Clients (Client 11, 12, 13, and 17 - 38) medical care which met their needs and provided them with optimal health. Medical assessments were not completed for Clients that refused and no plan was created to ensure the assessments were completed the facility's physicians did not complete exams or review Clients’ files to ensure they received treatment in line with their needs the facility's nursing department did not communicate Clients medical needs to direct care staff, the interdisciplinary team (IDT), or facility physicians and the facility's medical department did not ensure Clients who were over 50 years old received a second COVID-19</td>
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booster shot as recommended by the Center for Disease Control. These failures resulted in Client 5 having their left eye surgically removed, permanent disfigurement, and less visual ability and 26 Clients did not receive the recommended prevention for COVID-19.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021, KFRI12 Revisit Survey on 07/14/2021, and KFRI13 Revisit survey on 04/12/2022.

Findings included ...

Observation, record review, and interview showed a client was not provided general and emergent health care to treat an eye infection. Refer to W322 for more details.

Record review and interview showed the medical department did not provide Clients with recommended treatments for COVID-19. Refer to W234 for more details.

Observation, record review, and interview showed nursing staff did not follow nursing policies and protocols when treating a Client's general and emergent health condition. Refer to W331 for more details.

This STANDARD is not met as evidenced by:

**W 318**

physician services

CFR(s): 483.460(a)(3)

The facility must provide or obtain preventive and general medical care.
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<td>W 322</td>
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Based on observation, record review, and interview the facility failed to provide general and emergent medical care to meet the needs of 1 of 6 Sample Clients (Client 5). This failure resulted in Client 5 suffering a left eye infection which was not fully assessed, didn't receive their prescribed treatment, the facility physician was not notified of the refusals of treatment. Client 5's eye infection worsened, the facility physician was not notified of the worsening condition, and Client 5 had to be transferred and admitted to the Hospital where their left eye was surgically removed. This failure resulted in the loss of Client 5's left eye, permanent disfigurement, vision loss, and placed all Clients at risk of not receiving necessary medical care when their physical condition required medical care.

This is a repeat citation from the KFRI11 Recertification survey on 05/06/2021, KFRI12 Revisit Survey on 07/14/2021, and KFRI13 Revisit survey on 04/12/2022.

Findings included ...

Observation on 06/15/2022 at 10:45 AM at Haddon House showed Client 5 sat outside on the patio area with their assigned staff. Client 5's left eye was flat, indicating the eye was missing, and the area around the eye socket was slightly swollen.

Record review of the facility's 5-Day Investigation Report 10190, dated 06/08/2022, showed Client 5 was seen by the facility physician on 05/16/2022 for left eye irritation with crusty and clear drainage. The facility physician noted the left eye was "red and draining for the last 24-48 hours. The examination of the left eye was limited due to
Continued From page 69
lack of cooperation and combativeness from Client 5. Conjunctiva (Inflammation of the transparent covering of the eye because of bacterial or viral infection or allergic reaction) and sclera (the part of the eye commonly known as the white) appear erythematous (superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.). Thick drainage noted in corner of eye. Unable to assess visual acuity or red reflex, of fundal exam. External and lids WNL (within normal limits).” The facility physician prescribed antibiotic eye drops to treat Client 5’s condition. An Acute Nursing Care Plan was written, but no Licensed Practical Nurse (LPN) or Attendant Counselor orders were initiated so that they would know how to monitor or care for Client 5’s eye infection.

Record review of Client 5’s Ninety Day Healthcare Assessment, dated 04/12/2022, showed that they had a diagnosis of glaucoma (a condition of increased pressure within the eyeball, causing loss of sight) and cataracts (a condition in which the lens of the eye becomes progressively opaque, resulting in blurred vision) and that Client 5 often refused their prescribed eyedrops to treat the condition.

Record review of Client 5’s Quarterly Drug Regimen Review, dated 04/12/2022 showed that Client 5 refused to take their prescribed eyedrops.

Record review of Rainier School’s Medication Administration Procedure, dated 01/25/2022, showed if medications were refused, the nurse’s initials will be circled in appropriate time/date block on the Medical Administration Record.
W 322  Continued From page 70

(MAR) and refusal documented on the back of MAR. The nurse must notify the Registered Nurse (RN) of the incident, who will then evaluate the situation and will notify the facility physician by phone for medications of significant impact i.e., cardiac, seizure, insulin or breathing treatment, or by telephone/voicemail of routine medications i.e., multivitamins, vitamin C or stool softeners. Multiple refusals would require notification of the pharmacist by email for review and replacement.

Record review of Client 5's Health Progress Notes, dated 05/16/2022 at 8:20 PM, showed Staff G, LPN, noted Client 5 was on alert charting for left eye irritation and redness. Antibiotic eye drops were attempted which Client 5 refused after multiple attempts. There was no indication that the nurse dispensing the eyedrops notified any facility physician of the refusal.

Record review of Client 5's Health Progress Notes, dated 05/17/2022 at 8:15 AM, showed Staff H, RN noted Client 5 started on antibiotic eye drops and that they had not been cooperative when attempting to administer them or allowing nursing to cleanse the eye drainage. The left eye continued to be red and draining yellow/white drainage. There was no indication that the nurse dispensing the eyedrops notified any facility physician of the refusal.

Record review of Client 5's Health Progress Notes, dated 05/17/2022 at 9:00 PM, showed Staff, I, LPN, noted that Client 5's left eye irritation remains and that administration of Client 5's antibiotic eye drops was very challenging. There was no indication that the nurse dispensing the eyedrops notified any facility physician of the challenges of administering the eyedrops.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>W 322</td>
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Record review of Client 5's Health Progress Notes, dated 05/18/2022 at 9:50 PM, showed Staff I, LPN, noted Client 5's eye remained irritated and eye drops were attempted. They noted the eye drops were difficult to give to Client 5. There was no indication that the nurse dispensing the eyedrops notified any facility physician of the challenges of administering the eyedrops.

Record review of Client 5's Health Progress Notes, dated 05/19/2022 at 7:20 PM, showed Staff J, Advanced Registered Nurse Practitioner (ARNP), noted Client 5's left eye was still red and had drainage. Client refused their attempt to administer the eyedrops. They stated that Client 5 was at risk for infection and that they will continue to monitor.

Record review of Client 5's Health Progress Notes, dated 05/21/2022 at 7:55 PM, showed Staff G, LPN, noted Client 5's left eye still had conjunctivitis and was red with drainage. The note contained no information about whether Client 5's antibiotic eye drops were attempted.

Record review of Client 5's Health Progress Notes, dated 05/22/2022 at 8:00 AM, showed Staff H, RN, noted Client 5's left eye had not worsened but still did not look completely healed. Client 5 was not cooperating with their antibiotic eye drops or their prescribed eye drops for glaucoma. Staff H determined that since Client 5 refused eye drops so much of the time that there was limited benefit. Staff H discontinued charting for left eye conjunctivitis. There was no indication that Staff H notified the physician concerning Client 5's numerous refusals of the antibiotic eye drops.
## Continued From page 72

**W 322**

**Eye drops that were ordered.**

Record review of Client 5's Medication Administration Record (MAR), dated May of 2022, showed Client 5 received only 3 doses of the 20 prescribed antibiotic eye drop doses. Nursing staff did not consistently use the required code for when the Client refused the eye drops, and did not complete the back of the MAR regarding the context of the refusals as required by facility policy. Notifications were not consistently made to a Registered Nurse (RN), physician, or the pharmacy regarding the refusals as required by facility policy "Medication Administration Procedure," dated 01/25/2022.

Record review of Client 5's Health Progress Notes from 05/22/2022 at 9:00 AM through 05/29/2022 at 8:15 AM, showed no information regarding Client 5's left eye conjunctivitis was provided.

Record review of Client 5's Health Progress Notes, dated 05/29/2022 at 9:00 PM, showed Staff K, RN, documented that Client 5's left eye remained reddened and continued to have copious amounts of thick white drainage. They documented that Client 5 was at risk of conjunctivitis and that the treatment for this condition was ended on 5/22/2022 by Staff H. Staff K stated that the writer had notified the facility clinic via email (during a weekend when the clinic was not staffed. The email would not have been seen until 05/31/2022.)

Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 12:06 PM, showed Staff F, facility Physician, documented a follow up to Client 5’s conjunctivitis. It stated Client 5
### Summary Statement of Deficiencies

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

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<th>Summary Statement of Deficiencies</th>
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<td>W 322</td>
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**Continued From page 73**

continued to have swollen lids and discharge from their eye. Staff F documented Client 5 would not allow an exam of their eye. Staff F prescribed a different antibiotic eye drop for Client 5. The facility physician noted that Client 5 should be considered for an ophthalmology consult.

Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 4:46 PM, showed Staff F, facility Physician, documented an addendum to their previous order. It stated that given the difficulty of administering eye drops, with Client 5, and the possibility of periorbital/perceptual cellulitis (an infection of the eyelid or the skin around the eye), they will start a course of oral antibiotics.

Record review of Client 5's Health Progress Notes, dated 05/31/2022 at 6:15 PM, showed Staff M, LPN, Client 5 was on alert charting for their left eye conjunctivitis to monitor drainage, swelling, and Client 5's lack of cooperation with treatment and using a warm compress. Staff M documented Client 5 refused the compress. Client 5 took their oral antibiotic medication. Staff M documented purulent (consisting of or containing pus) drainage in Client 5's left eye as well as swelling. Staff M did not report the refusal of the warm compress treatment to the facility physician.

Record review of Client 5's University of Washington Medicine Harbor Medical Center Discharge Summary, dated 06/13/2022 at 10:50 AM, showed on 06/10/2022 the hospital completed surgery to remove their left eye.

Record review of Client 5's file showed no communications from any facility department to...
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<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>W 322</td>
<td>Continued From page 74 the facility physician regarding the historical refusals of eye drops with relation to the antibiotic eye drop ordered for Client 5's conjunctivitis on 05/16/2022. Record review of the facility's 5-Day Investigation Report 10190, dated 06/08/2022, showed that Client 5's eye infection could have likely been prevented if Client 5 had received appropriate medical care prior to the hospital transfer. During an interview on 06/15/2022 at 5:30 PM Staff A, RN, stated that all the Health Progress Notes, MARs, Physicians Orders, and Clinical Notes contained in the 5-day investigation were directly quoted from those documents. They verified that there were no Health progress notes from 5/22/2022 through 5/31/2022 regarding Client 5's eye condition. They stated that the prescribing physician was not made aware of Client 5's refusal of eyedrops until 05/31/2022. During an interview on 06/16/2022 at 11:30 AM, Staff B, Program Area Team (PAT) Director, Staff C Superintendent, Staff D, RN, and Staff E, Medical Director, stated that there were several instances where facility nursing did not follow the facility's policies and procedures when Client 5 refused their antibiotic eye drops. They stated that the IDT was not consulted or informed about the Client's new medical condition. They stated that the facility did not have a plan in place to deal with Client 5's refusal of medical assessments or treatments. PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(ii) The facility must provide or obtain annual physical...</td>
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W 324 | Continued From page 75

examinations of each client that at a minimum includes immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

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This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide Center for Disease Control (CDC) recommended treatments for 1 Sample Client (Client 4) and 25 expanded Sample Clients (Client 11, 12, 13 and 17 - 38) when Clients over the age of 50 were not provided their second COVID-19 booster shot. This failure left all Clients vulnerable to infection without the best recommended treatment for COVID-19.

Findings included ...

Record review of the CDC media statement, dated 03/29/2022, showed the CDC updated their recommendations for people over the age of 50 to receive a second booster. The booster shot could be given 4 months after the initial booster shot.

Record review of Rainier School PAT C's "Client Covid Booster List", dated 06/15/2022, showed that 25 Clients over the age of 50 had not received their second COVID-19 booster shot and all 25 of the Clients had received their first booster shot over 4 months prior.

During an interview on 06/16/2022 at 1:04 PM, Staff E, Medical Director, and Staff MM, Pharmacy Director, stated that the COVID-19 Booster List did show that 25 Clients over the age
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>W324</td>
<td>Continued From page 76 of 50 had not received their 2nd booster shot and it had been at least 4 months since their initial booster shot.</td>
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<tr>
<td>W331</td>
<td>NURSING SERVICES</td>
<td>CFR(s): 483.460(c)</td>
<td>The facility must provide clients with nursing services in accordance with their needs.</td>
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This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that facility nurses responded timely to medical concerns, communicated with the physician or other medical professionals, monitored progress following an illness, and provided training for direct care staff to know how to monitor and care for Client 5’s medical condition for 1 of 6 Sample Clients (Client 5). This failure resulted in Client 5’s left eye infection not being appropriately cared for leading to Client 5’s hospitalization and subsequent surgical removal of their left eye and potentially putting all Clients at risk for their medical needs not being met.

This is a repeat citation from KFRI11 completed 05/06/2021.

Findings included ...

Record review of Client 5’s Interdisciplinary Team (IDT) meeting notes, dated 03/22/2022, showed Client 5 had a history of refusing eye drops. They were tactile defensive (a hypersensitivity to touch) and became extremely stressed and resistive to hands-on training and treatment unless it was very brief. It showed if they said no to a request, they would not change their mind. It showed if...
Client 5 refused eye drops the IDT did not recommend restraining them to administer drops. Client 5 had a Service Care Plan (SCP) to address avoidance of chaotic environments as they were more apt to accept their eye drops if, the environment was quiet, they were seated in a chair, and demonstrating acceptance of the procedure.

Record review of the facility's 5 Day Investigation Report #10190, dated 06/08/2022, showed:

A November 2021 Ophthalmology Consult, a March 2022 Annual Healthcare Assessment, a 04/12/2022 Interdisciplinary Team discussions during a 90-Day review, and the previous three months of Medication Administration Records (MARS) recorded frequent refusals that indicated Client 5 was not compliant with eye-drop administration to treat their glaucoma/cataracts.

On 05/16/2022 Client 5 was seen in the clinic and antibiotic eyedrops were ordered. An Acute Nursing Care Plan was implemented but no Licensed Practical Nurse (LPN) or Attendant Counselor (AC) orders were initiated as required so that Direct Care Staff would know how to monitor or care for Client 5’s eye infection.

Client 5 allowed nurses to administer three eye drops of the twenty ordered over the course of their treatment.

Health Progress Notes indicated nurses attempted to administer the eyedrops, but Client 5 frequently refused. Nurses did not follow up with the facility physician or the pharmacy regarding the refusals.
### Summary Statement of Deficiencies

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

<table>
<thead>
<tr>
<th>Event ID</th>
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<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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| W 331    |        |     | Continued From page 78

Staff H, Registered Nurse (RN), discontinued the Alert charting and resolved Client 5's Acute Nursing Care Plan despite documenting that the eye infection had not fully resolved. No follow-up medical assessment was requested and there were no progress notes regarding Client 5's eye condition from 05/22/2022-05/28/2022.

On 5/29/2022 Staff G, LPN, noted that Client 5 had previously had conjunctivitis (Inflammation of the transparent covering of the eye because of bacterial or viral infection or allergic reaction.) in their left eye and the eye still had redness and drainage.

On 05/29/2022 Staff K, RN, noted that Client 5's left eye remained reddened and continued to have large amounts of thick white drainage.

An email was sent by Staff II, LPN, to clinic staff on 05/30/2022 regarding increased redness and drainage to Client 5's left eye and requested they be seen in the clinic (during a weekend when the clinic was not staffed. The email would not have been seen until 05/31/2022.) No documentation in the progress notes was written.

On 06/01/2022 Staff J, Advanced Registered Nurse Practitioner, assessed Client 5's left eye and decided to send Client 5 to the hospital.

The facility investigation concluded: the incident could have possibly been prevented if the initial left eye infection had been treated until healed Client 5 had not received appropriate medical care prior to the transfer to the hospital. No nursing orders were in place to guide medication and treatment for LPNs or direct care staff.
Continued From page 79

regarding the Acute Nursing Care Plane in place to treat the initial conjunctivitis diagnosis. No medical follow up was requested by nursing after the initial treatment order was completed. There was poor documentation in the progress notes by direct care staff and nursing and no plan in place for medical refusals and Client 5 had likely suffered pain and discomfort.

Record review of Client 5’s University of Washington Medicine Harbor Medical Center Discharge Summary, dated 06/13/2022 at 10:50 AM, showed on 06/10/2022 the hospital completed surgery to remove their left eye.

During an interview on 06/15/22 at 5:30 PM Staff A, RN, stated that all the Health Progress Notes, MARs, Physicians Orders, and Clinical Notes contained in the 5-day investigation were directly quoted from those documents. They verified that there were no Health Progress Notes from 05/22/2022 through 05/31/2022 regarding Client 5’s eye condition. They stated that the prescribing physician was not made aware of Client 5’s refusal of eyedrops until 05/31/2022.

During an interview on 06/16/2022 at 11:30 AM, Staff B, Program Area Team (PAT) Director, Staff C Superintendent, Staff D, RN, and Staff E, Medical Director, stated that there were several instances where nursing did not follow the facility’s policies and procedures when Client 5 refused their antibiotic eye drops. They stated that the IDT was not consulted nor informed.

COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE

CFR(s): 483.460(f)(2)
## Statement of Deficiencies and Plan of Correction

### NAME OF PROVIDER OR SUPPLIER

RAINIER SCHOOL PAT C

### STREET ADDRESS, CITY, STATE, ZIP CODE

RYAN ROAD
BUCKLEY, WA 98321

### Summary Statement of Deficiencies

---

**W 352**

Continued From page 80

Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure 1 of 6 Sample Clients (Client 4) received an annual dental examination. This failure resulted in no preventative screening for oral cancer nor assessment of the health of Client 4's remaining teeth.

Findings included ...

Review of Client 4's file showed there was no dental assessment completed within the past year. It showed Client 4 refused to allow the assessment on 02/24/2022, 03/14/2022, and 03/28/2022.

Record review of Client 4's Individual Habilitation Plan (IHP), dated 05/05/2022, showed Client 4's most recent dental assessment was on 04/21/2021 as they refused their dental appointment. The IHP showed they had two teeth, gum disease with severe bone loss, fair oral hygiene, moderate plaque (a sticky film that coats teeth and contains bacteria), and calculus (plaque that has hardened into a calcium compound). The IHP showed no plan to get the dental assessment completed.

During an interview on 06/23/2022 at 9:44 AM, Staff CC, Qualified Intellectual Disability Professional, stated that Client 4 did not have a current dental assessment.

---

**W 352**
The facility must provide a sanitary environment to avoid sources and transmission of infections.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 of 6 Sample Clients (Client 4) received an annual dental examination. This failure resulted in no preventative screening for oral cancer nor assessment of the health of Client 4's remaining teeth.

Findings included ...

Review of Client 4's file showed there was no dental assessment completed within the past year. It showed Client 4 refused to allow the assessment on 02/24/2022, 03/14/2022, and 03/28/2022.

Record review of Client 4’s Individual Habilitation Plan (IHP), dated 05/05/2022, showed Client 4’s most recent dental assessment was on 04/21/2021 as they refused their dental appointment. The IHP showed they had two teeth, gum disease with severe bone loss, fair oral hygiene, moderate plaque (a sticky film that coats teeth and contains bacteria), and calculus (plaque that has hardened into a calcium compound). The IHP showed no plan to get the dental assessment completed.

During an interview on 06/23/2022 at 9:44 AM, Staff CC, Qualified Intellectual Disability Professional, stated that Client 4 did not have a...
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>(X2) MULTIPLE CONSTRUCTION</th>
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| R | 0 /29/2022 |

### NAME OF PROVIDER OR SUPPLIER

RAINIER SCHOOL PAT C

### STREET ADDRESS, CITY, STATE, ZIP CODE

RYAN ROAD
BUCKLEY, WA 98321

### SUMMARY STATEMENT OF DEFICIENCIES

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| W 454 | Continued From page 82 current dental assessment. | W 454 |

| ID | PREFIX | TAG |

This document was prepared by Residential Care Services for the Locator website.
Exhibit E
This report is the result of an unannounced complaint survey for #9095 at Rainier School, Program Area Team E, on 01/05/2022, 01/06/2022, 01/07/2022, 01/10/2022, 01/11/2022, and 01/12/2022. Deficient practice was identified, and Immediate Jeopardy citations were declared at W127 and W154. Client 1 had a documented history of potentially life-threatening behaviors that put the Client at risk for choking. The facility did not address those behaviors and Client 1 choked and died on 12/20/2021. The facility investigation of Client 1’s death did not identify the known risks or whether the facility had a sufficient protection plan related to the Client’s harmful and potentially life-threatening behaviors. All Clients at the facility that exhibit potentially harmful or potentially life-threatening behaviors are at risk for significant harm or death. The Condition of Participation at W122 for Client Protections was found out of compliance as a result. Additional standard level deficient practice will also be cited. The facility was notified of the Immediate Jeopardy findings on 01/12/2022 at 4:00 PM. The facility has not provided an immediacy removal plan.

This survey was conducted by:
DSHS Aging and Long-Term Support Administration
Residential Care Services
ICF/IID Survey and Certification Program

The facility must ensure the rights of all clients.
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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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<tbody>
<tr>
<td>W 122</td>
<td>Continued From page 1 This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to protect 1 of 1 Sample Clients (Client 1) from choking. Client 1 had known, long-standing behaviors related to getting and eating food unsupervised that placed them at risk of choking. The facility did not provide training or supervision to prevent the behaviors that resulted in the choking incident. The facility did not thoroughly investigate the incident to determine why it happened or if it could have been prevented. This failure resulted in the death of Client 1 and puts all Clients with behaviors that are potentially harmful or life threatening at risk when facility investigations do not determine the &quot;why&quot; of the incident, the appropriateness of the facility's plan (not just if the plan in place was implemented correctly) for the Client, and all other aspects and circumstances of the incident in order to prevent recurrence. Findings included ... Record review of Client 1's 5-day Investigation Report, dated 12/22/2021, showed that on 12/20/2021, Client took food from the kitchen at the house, ate the food in a bathroom unsupervised, choked, and died. The investigation identified that Client 1 was skilled at getting food from the house kitchen when staff were not aware and going to the back of the house to eat it. Record review of Client 1's Psychology Review, dated 12/02/2021, showed Client 1 had 14 observed episodes of inappropriately taking food (defined as taking food or drink items at the house or from others when it was not Client 1's to...</td>
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- 28 episodes of taking food and drinks from inappropriate places (defined as taking items from an inappropriate source, such as a garbage can, drinking dirty dishwater, or drinking from dirty cups) in the month of November 2021. The notes section of the review showed that Client 1 had been taking food to their room, and drinking from cups and soda cans left in garbage cans. Staff B, Psychology Associate, completed the review.

Record review of Client 1’s Individual Habilitation Plan (IHP—a facility document created to provide care, training, and treatment for Individuals with Intellectual Disabilities), dated 02/09/2021, showed Client 1 was unaware of potential dangers and hazards and did not have the ability to handle emergencies. The IHP identified that Client 1 would inappropriately take food and drinks from the house and from other people, and would inappropriately take items to eat and drink from garbage cans. The IHP did not contain any training, supervision, or actions to prevent Client 1 from taking food inappropriately, from inappropriate places, or to provide supervision while Client 1 ate the food.

Review of Client 1’s IHP revisions, dated 01/14/2021-10/21/2021, showed no changes to the Clients IHP in relation to the identified behaviors.

Record review of Client 1’s Qualified Intellectual Disability Professional (QIDP) Review, dated 11/08/2021, showed Client 1 was taking items from inappropriate places, which "likely means [the Client] was digging in the garbage can for food or soda cans."
W 122 Continued From page 3

Record review of Client 1's Speech-Language Communication Assessment, dated 02/08/2021, showed Client 1's Interdisciplinary Team (IDT - a group of staff members from different fields that work together to provide the best care and outcome for Clients) approached the Speech Language Pathologist (SLP) with concerns about Client 1's ability to chew food and manage the food in their mouth because Client 1 was toothless. The SLP recommended additional testing to determine the Client's ability to chew and manage the food in their mouth while eating.

An email dated 01/07/2022, in response to the surveyors request for test results related to Client 1's swallowing, showed facility Resident Information Services staff could not find any test results for Client 1 related to their ability to chew or swallow food.

During an interview on 01/11/2022 at 11:00 AM, Staff C, QIDP, when asked if the testing had been completed as recommended by the SLP, stated that Client 1's IDT discussed the recommendation and decided it was not a "dire need".

Record review of a facility email written by Staff G, Advanced Registered Nurse Practitioner, dated 12/21/2021, in response to the death of Client 1, identified that Client 1 had coughing issues in the past because they took very large bites of food and, "[The Client] steals food on a regular basis especially when hungry and dangerously shoves the food in [their] mouth."

The email stated that staff were to remind the Client to take small bites of food and the choking incident was an accident that happened because Client 1 did not have any teeth and ate a whole piece of bread quickly. The email stated, "Had
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat E  
**Street Address, City, State, Zip Code:** 320 Ryan Road, Buckley, WA 98321

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<tr>
<th>ID</th>
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<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
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<th>Tag</th>
<th>Provider's Plan of Correction</th>
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| W 122 | Continued From page 4  
[the Client] actually consumed bite size pieces of the bread this undoubtedly would not have happened."

Record review of Client 1's Annual Healthcare Assessment (AHCA), dated 12/07/2021, showed that in July 2020, "Later that month, [Client 1's first name] self-harm increased to where [they] was shoveling food into [their] mouth and getting angry with staff when they attempted redirection to slow down. This put [them] at a high risk for choking." The AHCA showed that in June 2021 Client 1 continued to have behaviors and, ...

...assaults regarding stealing food ...

Review of Client 1's supplemental documents, provided by the facility with the facility investigation of Client 1's death, and used in the facility's investigation, showed that between 2007 and 2021 Client 1 had a history of potentially harmful and life-threatening behaviors. Client 1 had multiple evaluations due to the concern with eating food too rapidly, taking too large of bites, "shoving" food in their mouth, "shoveling" food in their mouth, "cramming" food in their mouth, "gumming" (Client 1 was toothless) food 0-12 times before swallowing, and was known to sneak and "steal" food from the kitchen at the house, the facility coffee shop, and from garbage cans. Facility staff identified that Client 1 usually ate appropriately while being monitored by staff. Facility assessments and Client plans showed that the facility did not address the above concerns, despite their knowledge of the unsafe behaviors Client 1 had related to food and how they ate.

During an interview on 01/11/2022, with Staff A, Program Area Team Director, Staff B, Psychology

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W 122 Continued From page 5

Associate, Staff C, Qualified Intellectual Disability Professional, Staff D, Developmental Disabilities Administrator (DDA), and Staff E, DDA, when asked about Client 1's history of eating too quickly, stealing food and hiding from staff to eat the food, all placing Client 1 at risk for choking, they responded that the facility did not identify Client 1 at risk for choking since they had not choked before.

Record review of facility 5-day Investigation Report R2021120006, dated 12/22/2021, showed that on 12/20/2021 Client 1 ate food while in a bathroom at the back of the house, without staff knowing. Direct Care Staff identified that Client 1 was choking and attempted to intervene, calling 911 and the facility emergency support team. Emergency Medical Services (EMS) personnel were unable to revive Client 1 and the Client died at the facility. The cause of death was due to a lack of oxygen as a result of choking on food. The facility investigation did not identify the long-standing, inappropriate behaviors Client 1 exhibited related to food. The investigation did not determine if Client 1 was correctly assessed as independent related to compulsive behaviors related to food. The investigation did not identify if the Client's treatment plan was sufficient to prevent the choking incident.

W 127 PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

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This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to protect 1 of 1 Sample Clients (Client 1) from harm when the facility did not develop training plans and provide supervision for Client 1’s known behaviors of taking food, eating food rapidly and in large quantities, and eating the food in places away from staff supervision. This failure resulted in Client 1’s death on 12/20/2021 from choking on food.

This deficient practice resulted in a determination of Immediate Jeopardy.

Findings included ...

Record review of facility investigation R2021120006, dated 12/22/2021, showed that on 12/20/2021 Direct Care Staff (DCS) heard Client 1 making noise. When DCS went to the shower room at the back of the house, Client 1 handed the DCS a small piece of bread. Client 1 continued to make noise and was attempting to go into their bedroom. DCS had Client 1 go to the living room instead. DCS determined that Client 1 had food stuck in their throat and began the Heimlich maneuver (a procedure that helps dislodge food from a person's throat). DCS called 911 and called for the facility's emergency medical team. Client 1 became limp and DCS began Cardiopulmonary Resuscitation (CPR). The facility's medical team took over CPR until the Emergency Medical Services (EMS) personnel arrived. When EMS arrived Client 1 did not have a heartbeat and was not breathing. When EMS personnel attempted to put a tube in Client 1's throat they noticed chunks of bread in their airway, the largest chunk removed was approximately the size of a golf ball. EMS pulled 2...
additional smaller chunks of bread from Client 1’s airway. Despite the medical treatment Client 1 received after choking, they died at the facility.

Record review of a facility email dated 12/27/2021, from a facility Physician, showed Client 1’s cause of death was confirmed by the county Medical Examiner to be from a lack of oxygen from choking on food.

Record review of Client 1’s Annual Healthcare Assessment (AHCA), dated 12/07/2021, showed Client 1 had a history of harming themselves in July 2020. The AHCA stated, "Later that month, [Client 1’s first name] self-harm increased to where [they] were shoveling food into [their] mouth and getting angry with staff when they attempted redirection to slow down. This put [them] at a high risk for choking." The AHCA showed that in June 2021 Client 1 continued to have behaviors and, "...assaults regarding stealing food ..." and in July 2021 Client 1 had an increase in demanding behaviors regarding food and drinks. The behaviors continued into August 2021. The AHCA identified that management of Client 1’s diabetes was difficult because of Client 1’s compulsive issues around food and Client 1 had been food seeking and having self-injurious behaviors (actions that cause harm to oneself) related to food. The AHCA showed Client 1 did not have any teeth and the section labeled, "Nutrition/Swallowing" did not include any information related to Client 1’s ability to chew or swallow food.

Record review of a facility email written by Staff G, Advanced Registered Nurse Practitioner, dated 12/21/2021 in response to the death, showed Client 1 had coughing issues in the past
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:**
RAINIER SCHOOL PAT E

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
320 RYAN ROAD
BUCKLEY, WA  98321

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<td>W 127</td>
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<td>Continued From page 8 because they took very large bites of food and, &quot;[They] steals food on a regular basis especially when hungry and dangerously shoves the food in [their] mouth.&quot; The email stated that staff were to remind the Client to take small bites of food and the choking incident was an accident that happened because Client 1 did not have any teeth and ate a whole piece of bread quickly. The email stated, &quot;Had [they] actually consumed bite size pieces of the bread this undoubtedly would not have happened.&quot; Record review of Client 1's Speech-Language Communication Assessment, dated 02/08/2021, showed Client 1’s Interdisciplinary Team (IDT-a group of staff members from different fields that work together to provide the best care and outcome for Clients) approached the Speech Language Pathologist (SLP-professional staff that assesses and treats communication skills and swallowing ability) assigned to Client 1 to see if Client 1 could have some testing done to evaluate their ability to safely chew and swallow food. The SLP assessed Client 1 and identified the Client did not consistently chew their food, did not consistently manage the food in their mouth, and the issues may have been worsened by Client 1’s lack of teeth. The SLP identified that Client 1 ate foods that could be difficult to chew for people without teeth. The SLP recommended that further testing of Client 1’s ability to safely manage the eating process could be helpful. An email dated 01/07/2022, in response to the surveyors request for test results related to Client 1’s swallowing, showed facility Resident Information Services staff could not find any test results for Client 1 related to their ability to chew or swallow food.</td>
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Review of Client 1’s supplemental documents, provided by the facility with the facility investigation of Client 1’s death, and used in the facility’s investigation, showed that between 2007 and 2021 Client 1 had a history of potentially harmful and life-threatening behaviors. Client 1 had multiple evaluations due to the concern with eating food too rapidly, taking too large of bites, "shoving" food in their mouth, "shoveling" food in their mouth, "cramming" food in their mouth, "gumming" (Client 1 was toothless) food 0-12 times before swallowing, and was known to sneak and "steal" food from the kitchen at the house, the facility coffee shop, and from garbage cans. Facility staff identified that Client 1 usually ate appropriately while being monitored by staff. Facility assessments and Client plans showed that the facility did not address the above concerns, despite their knowledge of the unsafe behaviors Client 1 had related to food and how they ate.

Review of interviews (within facility investigation R2021120006 related to the choking incident and subsequent death on 12/20/2021) with staff present on the date of Client 1’s death showed, "[They] did have a known behavior of stealing food." and, "...Client [Client 1’s last name] is very sneaky, had a known behavior of stealing food and would go eat it in the back area of the building, the toilet area, or [their] bedroom. [DCS] said [Client 1] was very watchful and would quickly get foods when staff were not present." Another staff confirmed, "...Client [Client 1’s last name] was skilled and practiced at getting food from the kitchen when staff were not around. [DCS] said that Client [Client 1’s last name] usually took [their] acquired food items to the..."
**NAME OF PROVIDER OR SUPPLIER**

RAINIER SCHOOL PAT E

**STREET ADDRESS, CITY, STATE, ZIP CODE**

320 RYAN ROAD
BUCKLEY, WA  98321

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| W 127             | Continued From page 10  
bathroom or [their] bedroom. Staff regularly encouraged him to eat where staff could watch [them] to make sure [they] were safe.* and, 
"[Them] sneaking that brownie along with soft bread on no liquid was a bad combination.*  
Record review of Client 1’s Positive Behavior Support Plan (PBSP), revised 07/15/2021, showed Client 1 would take food and drinks from the kitchen and other places on campus, and would also take food and drink items from garbage cans. Client 1 would also drink dirty dishwater from the kitchen sink, and drink from dirty cups. The PBSP did not identify or address Client 1’s inappropriate behaviors of eating too quickly, taking too large of bites of food, or taking food to an isolated place to eat it. There were no training plans, no special supervision for Client 1 related to their inappropriate behaviors related to food, nor any restrictions around getting food by themselves.  
Record review of Client 1’s Individual Habilitation Plan (IHP), dated 02/09/2021, showed Client 1 was not aware of potential dangers or hazards and did not have the ability to assess or handle an emergency. The IHP showed staff would document each time they saw Client 1 take food or drinks from the house or if it wasn’t Client 1’s food or drink, and when they saw Client 1 take items from the garbage can or drink dirty dishwater. The IHP did not have a training plan to address Client 1’s eating food too quickly, taking too large of bites, or taking food to an isolated place to eat. The IHP did not have a training plan to address Client 1 taking items from the garbage or drinking dirty dishwater.  
During an interview on 01/11/2022 at 11:00 AM, |
| W 127             |                                                                                               |                   |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G046

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED
C 01/12/2022

NAME OF PROVIDER OR SUPPLIER
RAINIER SCHOOL PAT E

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X5) COMPLETION DATE

W 127 Continued From page 11
with Staff A, Program Area Team Director, Staff B, Psychology Associate, Staff C, Qualified Intellectual Disability Professional, Staff D, Developmental Disabilities Administrator (DDA), and Staff E, DDA, they stated that the facility did not have training plans or special supervision requirements for Client 1 regarding taking food and eating it in an isolated area, taking too large of bites, or eating too quickly. Staff C stated that the IDT was aware of Client 1’s behavior related to eating food but had determined the risk the behaviors presented did not require training, increased supervision, or restrictions.

W 154 STAFF TREATMENT OF CLIENTS
CFR(s): 483.420(d)(3)

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 the death of 1 of 1 Sample Clients (Client 1) when they choked to death when eating food unsupervised. The investigation looked at how staff reacted to the situation of finding Client 1 choking, but did not consider the facility's training plans or supervision for Client 1’s potentially harmful or life-threatening behaviors around food and did not consider facility assessments of Client 1’s behaviors related to food to determine if there were risks for Client 1 that should have been managed differently. This failure prevented the facility from knowing what part of the facility's plan had failed as it related to the choking death and whether the facility had properly treated and protected Client 1 around their food behaviors. This puts all Clients with potentially harmful or life-threatening behaviors at risk for potential harm when the facility does not have evidence that all alleged violations are thoroughly investigated.
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<td>not look at all aspects of incidents to ensure they know and consider everything about an incident.</td>
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<td>This deficient practice resulted in a determination of Immediate Jeopardy.</td>
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<td>Findings included ...</td>
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<td>Record review of facility 5-day investigation R202112006, dated 12/22/2021, showed Direct Care Staff (DCS) found Client 1 in a bathroom at the back of the house. Client 1 handed DCS a small piece of bread and attempted to go into their bedroom. DCS had Client 1 go into the living room and determined that Client 1 was choking. DCS intervened and called for emergent medical help from the facility medical team and 911. DCS began CPR when Client 1 lost consciousness and Emergency Medical Services (EMS) personnel took over upon their arrival. Despite the medical care, EMS could not revive the Client and Client 1 died at the facility. The facility investigation included the following questions.</td>
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<td>1. What caused Client 1 to choke on 12/20/2021?</td>
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<td>The facility investigation determined that Client 1 secretly obtained, and quickly ate a brownie, an individual box of cereal, and most of a slice of bread. The paramedics removed a golf ball size piece of food from Client 1's airway during their attempts to revive the Client. The facility investigation did not address the facility's treatment plan for Client 1's behaviors around food and its adequacy or whether it played a role in the Client's death. The investigation did not address the facility's supervision level for Client 1 and what, if any, role it played in the Client's death. The investigation did not identify any risks for Client 1 around their long-standing history of</td>
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eating too quickly, taking too large of bites, and eating in their bedroom or a bathroom.

2. Was Client 1’s death directly caused by the action or inaction of facility staff? The facility investigation determined that the choking death was an accident and staff did not directly cause Client 1’s death. The investigation concluded the incident was not preventable because Client 1 was independent (did not need staff supervision), and Client 1 was skilled at getting food and then eating it in their bedroom or a bathroom, away from DCS. The investigation did not consider whether Client 1’s Interdisciplinary Team (IDT- a group of staff members from different fields that work together to provide the best care and outcome for Clients) had correctly assessed Client 1 as independent in light of assessments about concerns related to Client 1’s inappropriate behaviors related to food.

3. Could the incident have been avoided? The facility investigation included witness interviews with staff that were working at the time of the incident, and they verified that Client 1 was skilled at taking food without staff knowledge, and would watch for opportunities to take food. Client 1 took food to eat it in an isolated area, they were known, long-standing behaviors of Client 1, and DCS, “watched for it the best they could.” The investigation did not consider whether the incident could have been avoided if the facility had known the Client had taken food on that date and then supervised the Client while they ate the food, or whether the facility should have provided additional supervision for Client 1, as a part of their treatment plan, to identify when the Client took food. The facility investigation did not interview the Qualified Intellectual Disability
W 154 Continued From page 14

Professional or other Interdisciplinary Team members who had provided assessments of Client 1's behaviors around food. The investigation did not identify the lack of training or supervision for Client 1 related to their behaviors and did not look at facility practices preceding the incident to determine if they were appropriate.

Review of supplemental documents, provided by the facility with the investigation, and used in the investigation of the Client's death, showed that between 2007 and 2021 Client 1 had multiple evaluations due to the concern with eating food too rapidly, taking too large of bites, "shoving" food in their mouth, "shoveling" food in their mouth, "crumming" food in their mouth, "gumming" (Client 1 was toothless) food 0-12 times before swallowing, and was known to sneak and "steal" food from the kitchen at the house, the facility coffee shop, and from garbage cans. Facility staff identified that Client 1 usually ate appropriately while being monitored by staff. Facility assessments and Client plans showed that the facility did not address the above concerns, despite their knowledge of the unsafe behaviors Client 1 had related to food and how they ate.

Record review of the facility's Standard Operating Procedure 2.25. "Incident Management," dated 06/18/2021, showed, "Information obtained should allow investigators to answer Who, What, When, Where, Why, and How. It should also lead to the establishment of a reasonable cause to the incident."

During an interview on 01/12/2022 at 1:46 PM, Staff F, Investigator 3, stated that the person investigating the incident determined what the
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<td>cause of the incident was, and when asked if the</td>
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<td>facility investigation answered why and how the</td>
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<td>incident occurred, Staff F answered, &quot;It should</td>
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