

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2015
NAME OF PROVIDER OR SUPPLIER RAINIER SCHOOL PAT A			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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS This report is the result of an annual recertification survey conducted between 3/2/15 and 3/11/15. In addition, complaint investigations were conducted for the following: #3068033, #3079747, #3033611, #3032445, #3021326, #3075422, #3074874, #3017359 and #3074594. The team consisted of the following surveyors: Kathy Heinz, Marci Caird, Gerald Heilinger, Claudia Baetge and Jim Tarr. A sample of 12 residents was drawn from a census of 112. The team expanded the sample to include 30 additional residents. *3/21/16 - 3068033 was included in the above narrative in error. It was not part of the survey. 3033611 was included in the survey but did not result in a citation. The Survey Team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long Term Care Administration Department of Social and Health Services PO Box 45600 Olympia, WA 98504-5600 Telephone: 360-725-2405 Fax: 360-725-2642	W 000			
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by:	W 102		5/1/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/29/2015

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.

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W 102	<p>Continued From page 1</p> <p>Based on observation, record review and interview the facility failed to meet the Condition of Participation in Governing Body by not exercising operating direction over the facility and by not meeting the Condition of Participation for Active Treatment and The Condition of Participation for Client Protections.</p> <p>Findings include: The governing body failed to exercise general operating direction in a manner that resulted in:</p> <ol style="list-style-type: none"> 1. The facility did not ensure there were adequate risk benefit analysis for the use of restraints, there were adequate policies addressing the use of chair restraints, or there were plans to reduce the use of the restraints. The facility did not ensure alarms were used only when there was a need. The facility did not ensure the human rights committee and guardians authorizing the use of the restraints fully understood all the risks and benefits associated with the use of the restraints. The facility did not ensure that residents sitting for long periods of time in restraints were checked and monitored for safety, or that residents were not subjected to alarms going off throughout the day. See W104 2. The facility did not meet the Condition of Participation for Active Treatment Services by not developing and implementing plans based on functional assessment, by not promoting self-management and by not ensuring adequate staffing to meet resident need. See W195 3. The facility did not meet the Condition of Participation for Client protections when it failed to protect resident rights', failed to ensure residents were free from restraints and were protected from staff neglect. The facility failed to ensure allegations were reported in a timely manner, residents were protected from further 	W 102			

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W 102	Continued From page 2 abuse and failed to thoroughly investigate a significant injury of unknown origin. The facility did not ensure corrective actions they identified were completed. See W 122	W 102			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure there were adequate risk benefit analysis for the use of restraints, there were adequate policies addressing the use of dining room chair restraints, alarms were only used when needed, and there were plans to reduce the use of restraints. This failure affected five Sampled Residents (Resident #1, #4, #6, #7 #12) and eight Expanded Sampled Residents (Residents #22, #27, #29, #31, #32, #33, #34, #35). This failure resulted in the human rights committee and guardians authorizing the use of the restraints without fully understanding all the risks and benefits, residents sitting for long periods of time in restraints without staff checking the Residents' health and safety, and homes with alarms going off throughout the day without any need. Findings include: Risk/Benefit Analysis Resident #4 Review on 3/6/15 of Resident #4's Individual Habilitation Plan (IHP) dated 2/6/15 revealed the following items were designated as restrictive: gait belt, Attends, chest and waist supports on toilet, wheelchair with (tilt in space) safety belt,	W 104			

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W 104	<p>Continued From page 3</p> <p>ankle huggers and foot straps, hospital bed with padded siderails with head of bed elevated, and standing frame. The only risk identified for these devices was: "[Resident #4's name] right to freedom of independent movement will be abridged". Interview on 3/10/15 with Staff CC verified there was no other explanation of risks associated with each of the restrictive components of Resident #4's plan.</p> <p>Resident #12</p> <p>Review on 3/9/15 of Resident #12's IHP dated 7/15/14 revealed the following items were designated as restrictive: protective cover, incontinence briefs, bed bath and freedom tub with harness, foot/ankle orthotics, low bed with scoop mattress, recliner/couch/sensory room chairs all with seatbelt, and mechanical lift and sling. The only risk identified for these devices was: "[Resident #12's name] right to freedom of independent movement will be abridged". Interview on 3/10/15 with Staff YY verified there was no other explanation of risks associated with each of the restrictive components of Resident #12's plan.</p> <p>Dining Room Chair Restraints</p> <p>Resident #6</p> <p>Observation at Buckley House on 3/4/15 between 9:45 AM and 11:30 AM revealed Resident #6 was sitting at the dining room table with a seatbelt fastened around her chest. There was a large Connect Four game in front of her. At 11:30 AM staff filled the "Connect Four" game with large plastic circles, removed the game from the table and served lunch. Resident #6 sat restrained to the dining room chair for 1 and 1/2 hours prior to lunch being served. At no time did staff check the restraint to ensure it was not too snug or if it was placed properly. At no time did staff ask Resident #6 if she wanted to sit</p>	W 104			

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W 104	<p>Continued From page 4</p> <p>somewhere else or if she was comfortable. Observation on 3/5/15 at Buckley house between 7: 10 AM and 8:12 AM revealed Resident #6 was sitting in a dining room area of the home. There was seat belt buckled around the middle of her chest. At 7:48 AM, staff pushed Resident #6's chair up to the table. At 8:12 AM, a staff served Resident #6 her breakfast. Resident #6 sat in the dining chair for 62 minutes before she ate breakfast.</p> <p>Review of Resident #6 ' s Individual Habilitation Plan dated 7/14/14 revealed under the section titled adaptive equipment and mechanical supports, Resident #6 had a chest support on her dining room chair. The plan indicated it was used only when resident #6 was eating.</p> <p>Review of the facility policy Standard Operating Procedure (SOP) 3.1 titled Adaptive Equipment and Mechanical Restraints revealed there are no policies addressing the maximum amount of time a resident should be left in a dining room chair restraint or how often a resident should be checked by staff while restrained in a dining room chair.</p> <p>Interview with Staff Q on 3/10/15 revealed the facility did not consider dining room chair seatbelts as restraints. The seatbelts were considered mechanical supports.</p> <p>Alarms Observation of Percival House on 3/3/15 in the dining room at 9:33 AM revealed an alarm began sounding. It was loud and intrusive. It did not appear that staff responded to the alarm which was located on the wall. Interview with Staff D revealed the alarm was for Resident #31 and that it was to alert staff when Resident #31 was out of his bed. Staff D further revealed she did not respond to the alarm because she knew a staff was making Resident #31 ' s bed at that time.</p>	W 104			

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W 104	<p>Continued From page 5</p> <p>Observation on 3/5/15 of Percival House in the dining room at 7:10 AM revealed the same alarm went off and again no staff responded. Interview with Staff D revealed she did not respond to the alarm as she knew Resident #31 was up and out of his room at that time. Observation on 3/3/15 of Percival House between 3:45 PM and 3:53 PM revealed the following Residents' alarms went off when the State Surveyor walked into the room for Residents #32, #33, #34, and #35. Each of the alarms sounded in the dining room area of the side of the house they lived on except Resident #34's which sounded in the dining room on the opposite side of the house from where his bedroom was located. Interview on 3/3/15 with Staff K revealed the alarms are not turned off during the day. She verified the alarms were only needed for when the Residents were in bed, which was usually at night.</p> <p>Observation on Devenish house on 3/6/15 at 11:00 AM revealed motion sensor alarms in bedrooms for the following residents: Resident #7, #22, #27, #29 and #1. The motion sensor alarm made a different sound for each resident. When staff or residents were within range of the motion sensor the alarm sounded. The sound was audible throughout the house during all hours of the day. The two main sensor alarm boxes sounded in the living room of the A and B side of the house. The alarm on the A side of the house was for: Resident #22, #1, #29 and on the B side of the house: Resident #7 and #27.</p> <p>Record review of Individual Habilitation Plans (IHPs) revealed a Motion Sensor schedule for use as follows: IHP dated 11/13/14 for Resident #7 scheduled during sleep hours; IHP dated 3/4/14 for Resident #1 scheduled during sleep hours; IHP dated 9/18/14 for Resident #29 scheduled during sleep hours; IHP dated 8/5/14</p>	W 104			

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W 104	Continued From page 6 for Resident #27 scheduled during sleep hours; IHP dated 4/15/14 for Resident # 22 scheduled for whenever in bed. Interview with Staff S on 3/10/15 at 3:00 PM acknowledged the sensor alarms were on 24 hours a day 7 days a week which conflicted with Individual Habilitation Plans of being on only during sleep hours or whenever in bed. Interview with Staff CC on 3/9/15 at 9:30 AM acknowledged the sensor alarms were for night time use only.	W 104			
W 122	483.420 CLIENT PROTECTIONS 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 resident rights' were protected, residents were free from restraints and were protected from staff neglect. The facility failed to ensure allegations were reported in a timely manner, residents were protected from further abuse and a significant injury of unknown origin was investigated thoroughly. The facility failed to ensure corrective actions based on investigative results were completed. Failure to ensure residents rights were protected resulted in residents being restrained for long periods of time, the right to privacy and an unobstructed view abridged without justification, allegations not being reported timely and a significant injury not being thoroughly investigated. See W125, W128, W149, W153, W-154, W155 and W157.	W 122		5/1/15	
W 125	483.420(a)(3) PROTECTION OF CLIENTS	W 125			

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W 125	<p>Continued From page 7</p> <p>RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and record review the facility failed to ensure the rights of three Sampled Residents (#1, #3 and #7) and 12 Expanded Sampled Residents (#13, #14, #15 #22 #26 #27 #37 #38 #39 #40 #41 #43) were protected when they obstructed the views from bedroom windows and displayed resident pictures and dietary restrictions in public areas. This failure resulted in residents' personal privacy not being protected and resulted in the residents' not having the abilities to make informed decisions regarding their rights to privacy and rights to look out through their bedroom windows.</p> <p>Findings include:</p> <p>1. Observation on Devenish House on 3/3/2015 at 9:00 AM revealed a hutch in the dining room areas of the A and B side of the house that displayed Residents' photo dietary cards visible to all guests/visitors for: Residents #1, #7, #22, #26, #27 #37, #38, #39, #40, #41 #43.</p> <p>Record review of IHP Guardian/Family Response/Assessment Form for Resident #7, the guardian checked ' No, I do not agree to photographs, use of first name (only) and art work may be published in Facilities newsletter or on bulletin boards at facility ' .</p> <p>Interview with Staff S on 3/10/15 at 11:00 AM acknowledged privacy concerns with displaying the residents' photos and dietary cards and</p>	W 125			

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W 125	<p>Continued From page 8</p> <p>indicated that facility care staff do have a binder available with all dietary recommendations/restrictions.</p> <p>2. Observation of [REDACTED] on 3/04/15 at 10:25 AM revealed Resident #15 's bedroom window was missing privacy curtains. Interview with Staff Z on 3/04/15 at 10:25 AM acknowledged Resident # 15 will pull any curtains down and the exterior shade was placed to provide privacy. Outside of Resident #15 's bedroom window on the exterior of the house was a shade hanging approximately 2 feet from the window that blocked Resident #15 's ability to look out his bedroom window. When standing outside of the house, between the shade and window anyone could view inside Resident 15 's bedroom. Interview with Staff S on 3-10-15 at 11:0 AM acknowledged Resident #15 's ability to look outside was blocked by the window shade.</p> <p>3. Observation made at [REDACTED] [REDACTED] on 3/3/15 at 2:59 PM and 3/4/15 at 10:35 AM found the facility had hung shades from the eaves of the roof outside the bedroom window for Residents #3 and #13 (who shared a bedroom) as well as the bedroom window of Resident #14. A full view of the outside from inside each bedroom was obstructed. In addition, the shades were hung in such a manner that allowed a space for someone to stand off to the side or between the shade and the window and look directly into the bedroom of each Resident. Staff VV was interviewed on 3/4/15 at 10:35 AM and reported the shades were used because drapes would get pulled down and two of the Residents (#13 and #14) liked to be naked in their bedrooms. Review of Individual Habilitation Plan records on 3/10/15 for Resident # 3 dated 9/16/14, Resident</p>	W 125			

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W 125	Continued From page 9 #13 dated 5/27/14 and Resident #14 dated 10/7/14 revealed the use of the shades were not addressed.	W 125			
W 128	483.420(a)(6) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure one of 12 Sampled Resident (#6) and one of one Expanded Sampled Residents (#30) were free from physical restraints. This failure resulted in residents being confined by restraints while on the toilet, in a recliner or while seated in a dining room chair for long periods of time. Findings include: Resident #6 Resident #6 was observed between 3/2/15 and 3/11/15 restrained by a seatbelt that was attached to a living room chair, restrained by a seat belt that was attached to a dining room chair 1. Observation on 3/2/15 at [REDACTED] at 10:55 AM revealed Resident #6 was sitting in a large overstuffed chair. There was a seatbelt attached to the chair. Resident #6 was buckled in the chair. At 11:11 AM Staff M assisted Resident #6 into a wheelchair and fastened the seatbelt. Staff M pushed the wheelchair into the dining room and assisted Resident #6 into a dining room chair and fastened a seatbelt around her waist. At	W 128			

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W 128	<p>Continued From page 10</p> <p>11:20 Staff R pushed resident #6's chair to the dining room table and placed a clothing protector around her neck.</p> <p>2. Observation on 3/3/15 at [REDACTED] 3:34 PM revealed Resident #6 was sitting in a recliner in the living area of the home. There was a seatbelt strapped across her waist. At 4:15 PM Staff M assisted Resident #6 from the easy chair into a wheelchair and buckled her in. Staff M then took Resident #6 into the dining room, assisted her to the dining room chair and buckled her in.</p> <p>3. Observation on 3/5/15 at [REDACTED] between 7:10 AM and 8:12 AM revealed Resident #6 was sitting in a dining room chair approximately two feet away from the dining room table. There was a seat belt buckled around the middle of her chest. At 7:48 AM, staff pushed Resident #6's chair up to the table. Resident #6 sat restrained in the dining chair for 62 minutes before she ate breakfast at 8:12 AM. No staff asked her if she wanted to sit anywhere else or if she was comfortable.</p> <p>4. Observation on 3/3/15 at 5:15 to 5:45 PM revealed Resident #6 was sitting in the living area of the home in a recliner with a seatbelt across her lap. She appeared to be sleeping.</p> <p>Record review on 3/9/15 of Resident #6's Individual Habilitation Plan (IHP) dated 7/14/14 revealed the dining room chair restraint was supposed to be applied only when Resident #6 was eating.</p> <p>Interview with Staff M revealed Resident #6 needed to be restrained because she is a fall risk.</p> <p>Interview with Staff N 3/6/15 on revealed the Occupation Therapy Department is looking at the use of all the restraints used at the facility and identifying ways to reduce the use of them.</p> <p>Interview with Staff Q on 3/11/15 regarding the use of the restraints in dining room chairs</p>	W 128			

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W 128	Continued From page 11 revealed the facility uses the seat belts that are attached to the dining room chairs as "positioning devices" and should only be used when eating. Resident #30 Observation on 3/5/15 at [REDACTED] revealed an Adult Training Program (ATP) took Resident #30 into the bathroom at 7:50 AM. The ATP staff came out of the bathroom. The ATP staff started assisting other residents to eat breakfast. At 8:17 AM, the surveyor asked the ATP staff to produce the toilet support log for Resident #30 as no one had checked on Resident #30. The ATP staff went into the bathroom Resident #30 was sitting in and gave the restraint log to the surveyor. Review of the record revealed the ATP staff had not entered the time she assisted Resident #30 to the toilet. Resident #30 sat, restrained on the toilet for 27 minutes until the surveyor intervened. Review of the hourly toilet support log for 3/5/15 revealed no documentation when Resident #30 was put on the toilet or when she had been checked or monitored. Review of the facility's policy title Standard Operating Procedure (SOP) 3.13 revealed residents placed in a "Toilet Support" device will be monitored at a minimum of every ten minutes. Interview with Staff M revealed Resident #30 needed to be kept on the toilet until staff could assist her to clean herself properly.	W 128			
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by:	W 149			

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W 149	<p>Continued From page 12</p> <p>Based on record review and interviews, the facility failed to implement facility procedures to ensure that three of three Expanded Sampled Residents (Residents #18, #19, and #20) were protected from neglect. Resident #18 was left unattended for an extended period of time in a bed bath trolley. Resident #19 was left with an alleged perpetrator after an allegation of abuse was made and Resident #20 did not receive medication as prescribed. These failures placed residents at risk for potential harm.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review on 3/3/15 of a facility investigation into an incident which occurred on 7/13/14 revealed Resident #18 had been left on a bed/bath trolley for a minimum of 2 hours and possible up to 3 ½ hours after a medical procedure was completed. Resident #18 had been placed on the trolley in preparation for a medical procedure. Resident #18 was not attended to during the time she was on the trolley and was not repositioned every 2 hours as required by her plan. Resident #18 was not able to move off of the trolley independently. Interview on 3/5/15 with Staff A verified Resident #18 should not have been left on the trolley unattended. On 3/9/15 the State Survey Team was notified of an incident of alleged abuse against Resident #19 which occurred on 3/6/15. The facility incident report revealed Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19's bare feet and pulling him up to a standing position. The incident was observed by Staff H and Staff U. Only Staff U told Staff B to stop and that it was not an appropriate way to treat Resident #19. Staff U reported Staff B stated Resident #19 liked being kicked and Staff U 	W 149			

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W 149	Continued From page 13 reported Staff H agreed Resident #19 liked being kicked. However, Staff U did not prevent Staff B from continuing to interact with Resident #19 and allowed Staff B to take Resident #19 into the bathroom behind a closed door. 3. A review on 2/18/15 of a facility incident report revealed Staff PP failed to administer a prescribed medication, [REDACTED] to Resident #20 on 12/17/14 and 12/18/14.	W 149			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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 record review and interviews, the facility failed to ensure four of four allegations of abuse, neglect, or mistreatment (Expanded Sampled Residents #18, #19, #21 and #22) were reported to the facility in a timely manner. In each instance, facility staff delayed their report to the facility. This failure prevented the facility from ensuring Residents were protected and from beginning an immediate investigation into the allegation. Findings include: 1. Review on 3/3/15 of a facility investigation of an incident which occurred on 7/13/14 revealed Resident #18 had been left on a bed/bath trolley for a minimum of 2 hours and possible up to 3 1/2 hours. Resident #18 had been placed on the trolley in preparation for a medical procedure that had Physician's orders to occur at 7:00 AM.	W 153			

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W 153	<p>Continued From page 14</p> <p>Resident #18 was not attended to during the time she was on the trolley and was not repositioned every 2 hours as required by her plan. Resident #18 was not able to move off of the trolley independently. Resident #18 was found on the trolley by Staff V at approximately 2:20 PM. Staff V did not report this incident to the facility until 11:10 PM of the same day. Interview with Staff A on 3/5/15 verified staff reported the incident late.</p> <p>2. On 3/6/15 at approximately 2:05 PM, Staff U observed an incident of alleged abuse against Resident #19. Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19's bare feet and pulling him up to a standing position. Staff U did not report this incident to the facility until 2:25 PM. Interview with Staff T on 3/9/15 verified there was a delay in reporting.</p> <p>3. Review on 3/3/15 of a facility incident report and investigation revealed on 8/4/14 Staff W observed Staff X push a chair into a dining room table, where Resident #21 was seated eating dinner that caused the table to rotate 60 degrees from its original position. Staff W was upset by this action and thought this was inappropriate. This incident occurred at approximately 5:00 PM but Staff W did not report this incident to the facility until the next day. Interview with Staff T on 3/9/15 verified there was a delay in reporting.</p> <p>4. Review on 3/10/15 of a facility incident report and investigation revealed on 6/5/14 at 3:15 PM Staff AAA discovered a narcotic medication (1 tablet of 300 mg [REDACTED] medication) for Resident #22 that remained in the medication drawer. Staff BBB also discovered the 8:00 AM medications: [REDACTED]</p>	W 153			

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W 153	Continued From page 15 [REDACTED] for Resident #22 had not been signed off as administered and notified Staff AA. Staff AA did not report this incident until 6/10/2014 following completion of facility internal investigation. Interview with Staff AA on 2/18/15 verified the medication errors occurred prior to the completion of the correction action.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to thoroughly investigate a significant injury of unknown origin for Resident #23 who had a fractured [REDACTED]. Failure of the facility to investigate significant injury may result in the facility not knowing what happened and thus not being able to rule out abuse and neglect or take appropriate corrective action. Findings include: Review on 3/2/15 of a facility investigation dated 9/25/14 revealed Resident #23 was making "angry faces" and had refused to participate in occupational therapy at approximately 2:00 PM in the afternoon. It was determined through an X-ray that Resident #23 had a [REDACTED] Interview with Staff NN regarding the incident on 3/6/15, with the facility investigation record present, revealed when she examined Resident #23's [REDACTED] she noted the abrasions were recent. The physician note dated 9/25/14 revealed: obvious linear abrasions/acute	W 154			

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W 154	<p>Continued From page 16</p> <p>contusion/bruising over [REDACTED]</p> <p>The facility investigator concluded that Resident #23 walked freely about the house and most likely hit her [REDACTED] on the metal door frame of the bathroom. The witness statements prepared by Staff B, H and I did not include information that would help determine when or where the injury might have occurred. Staff did not indicate when they last saw Resident #23.</p> <p>Review of the facility's post position scheduled revealed Staff B was assigned to work with Resident #23 the day the injury was discovered. Staff B wrote in his witness statement: "was sitting next to Resident #23 in her chair and she started making angry faces and I was holding her [REDACTED]. Staff B wrote he had cued Resident #23 to go to the bathroom and get ready for the day." Staff B wrote "morning activities of daily living went fine and upon ADL's I didn't notice anything that looks like a bruise." Staff B indicated Resident #23's movements throughout the day seemed normal.</p> <p>The witness statement dated 9/25/14 for Staff H revealed he was working the day the injury was discovered, he wrote: "unknown fall or ran into something [REDACTED]."</p> <p>The witness statement dated 9/25/14 for Staff I revealed she wrote: "Possible fall or door jamb."</p> <p>The facility investigation did not indicate the physician was interviewed about the injury, if Resident #23 was unsteady on her feet or if staff were working their post positions as assigned.</p> <p>Interview on 3/6/15 with Staff T revealed Resident #23 would not have been able to get up by herself if she had fallen.</p> <p>The facility investigation revealed that under the section titled: follow up and plan of correction, the box was marked "no." However, on 9/26/14 an AD HOC was held and it was determined a</p>	W 154			

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W 154	Continued From page 17 sensor would be placed by Resident #23 's bed to alert staff if Resident #23 got out of bed. On 11/25/14, Resident #23 fell off the toilet and fractured [REDACTED]	W 154			
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to protect residents when they allowed two staff that were implicated in an incident of alleged abuse to continue to work, and also allowed another staff to continue to administer medications to residents before the corrective action from an earlier medication error had been completed. Failure of the facility to implement protective measures when staff are accused of neglect or abuse may place residents at risk of further neglect and abuse. Findings include: 1. On 3/6/15 at approximately 2:05 PM, Staff U observed an incident of alleged abuse against Resident #19. Staff B was alleged to have kicked Resident #19 in an attempt to get him to stand up. Then Staff B attempted to have Resident #19 stand up by standing on Resident #19 's bare feet and pulling him up to a standing position. This incident was reported by Staff U and was also witnessed by Staff H. State Surveyors observed Staff U working with residents after the incident had been reported. No measures to protect Residents from Staff U or Staff H had been taken by 3/9/15. Interview with Staff A on 3/9/15 revealed the facility was not aware of Staff H 's involvement in the incident	W 155			

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W 155	Continued From page 18 2. Review of a facility investigation dated 12/9/14 Staff PP was alleged to have made a medication error when she failed to give Resident #43 a medication (redacted). The facility conducted an investigation of the error and on 12/22/14, Staff PP received an oral reprimand from Staff AA and a Performance Meeting Record was written. However, prior to the completion of this corrective action process Staff PP was allowed to continue to administer medications and committed two more medication errors when she failed to give Resident #20 a prescribed medication (redacted) on both 12/17/14 and 12/18/14. Interview with Staff AA on 2/18/15 verified the medication errors occurred prior to the completion of the correction action.	W 155		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interviews and record reviews the facility failed to put padding on the headboard for one Expanded Sampled Resident (Resident #24), failed to follow up on an Occupational Therapy visit for one Expanded Sampled Resident (Resident #25), allowed staff to administer medication to Expanded Sampled Resident (Resident #20) prior to completion of a Plan of Correction from a previous medication error, and did not follow the recommendation that a cushion tube be placed over a belt buckle of one Expanded Sampled Resident (Resident #28). These failures placed residents at risk for further injuries.	W 157		

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W 157	<p>Continued From page 19</p> <p>Findings include:</p> <p>1. Observation on 3/3/15 at 7:42 AM of Resident #24 's bedroom found no padded headboard in use.</p> <p>Record review on 3/10/15 at 2:30 PM of an Incident Report (IR) revealed on 2/6/15, Resident #24 had a bruise and abrasion on the right side of her forehead.</p> <p>Record review on 3/10/15 at 2:30 PM of the facility 's investigation report found staff believed the injury was caused by Resident #24 's headboard. The investigation report also stated on 10/25/13 Resident #24 hit her head on her headboard causing an injury. Per the investigation report, the interdisciplinary team (IDT) discussed the current incident at the 2/12/15 house meeting and decided at that time a referral should be done for assessing Resident #24 's bed for padding.</p> <p>Record review on 3/10/15 at 8:55 AM of Work Request #00087237 found the request for padding the headboard of Resident #24 's headboard. This Work Request had the requested priority of " URGENT. "</p> <p>During an interview on 3/3/15 at 8:55 AM with Staff EE, he stated PT (Physical Therapy) or OT (Occupational Therapy) were supposed to evaluate Resident #24 's headboard for the possibility of using a padded headboard. He did not know if that had been done yet. He also said the evaluation was to be done as a result of an incident report from awhile back where staff thought Resident #24 hit her head on her headboard.</p> <p>Interview on 3/10/15 at 8:50 AM with Staff LL in the maintenance office revealed the maintenance shop had not received the work order for Resident #24 's padded headboard. He was able to track the work request via computer and</p>	W 157			

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W 157	<p>Continued From page 20</p> <p>stated the PAT A director signed off on the work order on 2/27/15 but it was still waiting for a signature from the Assistant Superintendent before his office could receive it.</p> <p>An interview on 3/10/15 at 11:25 AM with Staff N revealed the OT department submitted a work order to pad Resident #24 's headboard to prevent any further injury.</p> <p>During an interview on 3/10/15 at 11:25 with Staff A, she stated there are two work order priority levels, urgent and regular. She said the urgent orders are taken care of first. While the surveyor was present, Staff A called Staff LL and asked for status of the work request. She then telephoned Staff MM and reported to the surveyor that Staff MM would approve the work request today.</p> <p>2. Observation on 3/4/15 at 10:28 AM of Resident #25 found her sitting in an adaptive chair leaning to her right side.</p> <p>Record review on 3/2/15 at 2:00 PM of a facility investigation found on 2/8/15, Resident #25 was discovered to have a bruise which facility staff determined was caused by Resident #25 's adaptive dining chair.</p> <p>Record review on 3/2/15 at 2:15 pm of Resident #25 's Occupational Therapy (OT) notes found on 2/27/15 the OT department assessed the named resident 's leaning when in her adaptive dining chair. The note stated " PT to consult next week. "</p> <p>Record review on 3/6/15 at 9:22 AM of Health Interdisciplinary Notes revealed a note written by a physician 's assistant on 2/26/15 requesting follow-up for Resident #25 in the clinic in one week to evaluate and consider possible physical therapy options. The resident 's primary care physician, Staff NN, signed in agreement of this plan the same day, 2/26/15.</p> <p>Record review on 3/6/15 at 9:25 AM of the</p>	W 157			

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W 157	<p>Continued From page 21</p> <p>physician ' s orders for 2/26/15 found no orders written for the follow up appointment as indicated in the Health Interdisciplinary Notes.</p> <p>During an interview on 3/6/15 at 10:28 with Staff OO she stated Staff NN appeared to agree with the physician ' s assistant on the Health Interdisciplinary Notes, but it did not get written on the physician ' s order. She said she would follow up with it.</p> <p>There was no documentation showing Resident #25 was taken to the clinic to consult for possible physical therapy options.</p> <p>3. A review of an Incident Report date 12/19/14 obtained from the facility on 2/18/15 found that Resident #20 was not given a prescribed medication [REDACTED] on 12/17/14 and 12/18/14 by Staff PP. A record review of a 5 Day Investigation Report dated 12/22/14 revealed that Staff PP had an extensive history of medication errors as detailed below:</p> <ol style="list-style-type: none"> 1. Six medication errors or omissions in 2014 2. Two medication errors or omissions in 2013 3. Four medication errors or omissions in 2012 4. Three medication errors or omissions in 2011 <p>The corrective actions taken by the facility regarding Staff PP ' s medication errors ranged from Performance Meetings, Letters of Expectations, oral reprimands and re-training. On 2/19/15 Staff PP received a Letter of reprimand from the facility for the medication errors for 12/17/14 and 12/18/14. The facility ' s corrective actions did not appear to be effective as the staff continued to make medication administration errors. The facility failed to protect the resident when it failed to look at patterns, frequency, and history of medications errors. The facility ' s Standard Operating Procedure 4.14 Medication Errors states " there is no</p>	W 157			

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W 157	Continued From page 22 acceptable incident rate for medication errors: " Interviews with Staff AA and Staff # QQ on 2/18/15 revealed that when investigating medication errors the facility looked at adverse outcomes, severity of the error and length of time between errors. Both reported that there was no threshold on when a staff had made too many errors. Neither staff could give an explanation as to why Staff PP had so many medication errors in 2014. 4. Review of a facility incident report dated 2/3/15 revealed staff noticed a bruise with a 2 to 3 inch spread on Resident #28's right hip. The facility determined the bruise was caused by the seatbelt buckle on the shower chair. The facility investigation indicated that Staff M would contact Staff N for consultation regarding a remedy. Interview with Staff N on 3/5/15 revealed she recommended placing a "pool noodle" (cushioned tube) over the belt buckle while Resident #28 showered. Staff N stated Staff M would be responsible for the purchase of the "pool noodle." Interview with staff M on 3/5/15 revealed she had not purchased the "pool noodle."	W 157			
W 186	483.430(d)(1-2) DIRECT CARE STAFF 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:	W 186			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2015
NAME OF PROVIDER OR SUPPLIER RAINIER SCHOOL PAT A			STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321		
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W 186	<p>Continued From page 23</p> <p>Based on observation and interviews, the facility failed to ensure sufficient staff were available in order to meet the needs of one Resident (Resident #1) of 12 sampled residents. The failure of the facility to ensure staff were available to meet the needs of Resident #1 resulted in Resident #1 not being able to work and or leave the dining room when he was finished eating. Findings include:</p> <p>Interview with Staff S on 3/3/15 at 9:30 AM acknowledged there were 14 residents residing on Devenish House with significant basic care needs which included 7 residents on the A side of the house (Resident #29, #2, #36, #37, #15, #1 and #22) and 7 residents on the B side of the house (Resident #7, #41, #27, #40, #26, #39 and #38. Several residents (Resident #26, #27, #42, #29, and #22) required additional supervision with toileting and that required staff assistance. In addition, several residents (Resident #22, #1, #29, #7 and #27) had motion alarms in their bedrooms for protection of injury that required staff to investigate when the alarm sounded.</p> <p>Staff S reported 4 direct care staff work on the house which includes 2 direct care staff on the A side of home and 2 direct staff on the B side of home during the AM and afternoon shift. Overnight shift has 2 direct care staff on the house which includes 1 direct care staff working the A side of the house and one direct care staff working the B side of the residence.</p> <p>Resident #1 received PRO (Protective Supervision) for known [REDACTED] behavior [REDACTED] item) and must remain in line of sight at all times.</p> <p>On 3/3/15, following a dinner meal 4:50 PM, Staff RR is observed bringing Resident #29 into the living room and assists him into a recliner and secures the seat belt and returns to the kitchen</p>	W 186			

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W 186	<p>Continued From page 24</p> <p>area to sweep the floor. Resident #1 is escorted into the kitchen where a chair is placed for Resident #1 to sit on while the ACM loads the dishwasher.</p> <p>Observation on 3/3/15 at 11:00 AM during the lunch meal, 3/4/15 at 4:00 PM during the dinner meal and 3/9/15 at 11:00 AM during the lunch meal Resident #1 is observed eating his meal and when finished brings his dishes to the kitchen. Various staff escort Resident #1 back to the dining room table where Resident #1 remains seated until other residents are finished with their meal.</p> <p>Interview with Staff S on 3/10/15 at 11:00 AM acknowledged Resident #1 is limited in what he can do as facility staff need to be near him at all times due to Resident #1's known [REDACTED] behavior [REDACTED] item). Staff S acknowledged Resident #1 could do a lot more and has a boring life. Staff S acknowledged Resident #1 requires line of sight supervision at all times, and Resident #1's daily routine is driven by staff responsibilities not Resident #1's choice. Staff S acknowledged there is not enough direct care staff to meet the needs of Resident #1.</p> <p>Interview with Staff BB on 3/10/15 at 3:00pm acknowledged staff does the best they can with staff available. Staff BB acknowledged Resident #1 will sit with them and Resident #1's activities are based on what staff needs.</p> <p>Interview with Staff CC on 3/9/15 at 9:30 AM acknowledged Resident #1 could work and is quite capable of doing more. By not having a one to one staff Resident #1 is not able to work. Staff acknowledged a request was made for additional staffing for Resident #1 that was denied.</p> <p>Record review of Psychological Assessment dated 2-17-15 revealed Resident #1 receives</p>	W 186			

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W 186	Continued From page 25 protective supervision defines as "line of sight and no more than 10 feet away from a staff member". Resident #1's quality of life was greatly enhanced by having all day meaningful employment that he enjoyed. As staff levels have decreased, Resident work hours have been cut because his work is limited to times that 1:1 supervision is available.	W 186			
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met.	W 195		5/1/15	
W 196	This CONDITION is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure staff provided a continuous, active treatment program for Residents to develop skills for greater independence, failed to encourage Residents to make choices and self-manage their daily routines, failed to ensure staff implemented programs which had been developed based on assessed needs, and failed to ensure there were enough staff assigned to meet the needs of all Residents. This failure prevented the residents from receiving necessary services and supports to promote greater autonomy and independence and resulted in the Condition of Participation of Active Treatment Services to be not met. Findings include: See W186, W196, W247, and W249	W 196			
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of	W 196			

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W 196	<p>Continued From page 26</p> <p>specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure four of 12 Sampled Residents (Residents #4, #5, #10, and #11) received a continuous, consistently implemented program of supports, services, and training to meet their needs. Failure to ensure Residents were provided active treatment prevented them from acquiring skills to increase their independence.</p> <p>Findings include: Resident #11</p> <p>1. On 3/3/15 from 9:23 AM to 9:55 AM, Resident #11 was observed seated in a wheelchair at a table in the dining room of the A side of Percival House. There was no activity occurring. At 9:33 AM a staff asked her if she wanted to do a puzzle and got a 9 piece non-interlocking wooden puzzle and placed it in front of Resident #11 and then walked away. She did not do the puzzle. Staff did not continue to engage with her. At 9:39 AM a different staff tried to get Resident #11 to do the puzzle. Again, she did not do the puzzle. The observation ended at 9:55 AM. Staff D was interviewed at the end of the observation and she revealed Resident #11 was new to the house.</p> <p>2. On 3/3/15 from 3:02 PM to 3:28 PM, Resident #11 was observed sitting at a table in the A side dining room of Percival House. There were</p>	W 196			

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W 196	<p>Continued From page 27</p> <p>wooden puzzles and a wooden stacking ring toy on the table. At 3:09 PM a staff handed Resident #11 one of the stacking ring pieces. Resident #11 put the piece back on the table. At 3:11 PM, Resident #11 was talking to herself in a loud voice saying " Get no shot today " and other phrases. At 3:18 PM a staff involved in New Employee Orientation sat with her and handed her pieces of the stacking ring toy. She put 8 pieces on when they were handed to her one at a time. At the end of the observation, an interview with Staff C revealed the purpose of the activity was to develop fine motor skills.</p> <p>3. On 3/4/15 from 10:00 AM to 10:58 AM, Resident #11 was observed lying on a couch on the A side living room of Percival House. A staff asked her if she wanted a snack and assisted Resident #11 to a dining room table. Resident #11 had milk and cookies. At 10:10 AM she finished her snack and a staff asked her, " Want to do an activity? ". They offered her a board with geometrically shaped blocks but she pushed it away. The staff then gave her a children ' s picture book which she began looking at. At 10:20 AM Staff K had her transfer back into her wheelchair, at which point she yelled " Want a cookie " , and " I want a cookie " . So Staff K assisted her to have more cookies, apparently unaware that Resident #11 had just had cookies a few minutes earlier. At 10:45 AM she was back lying on the couch. At 10:56 AM a staff rubbed some lotion on her arms and hands and directed Resident #11 to rub it in completely. At 10:58 AM she was back in her wheelchair to get ready for lunch.</p> <p>4. On 3/6/15 from 9:25 AM to 10:03 AM, Resident #11 was observed in the dining room of her home at Percival House. The initial observation revealed she was sitting in her</p>	W 196			

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W 196	<p>Continued From page 28</p> <p>wheelchair at a table. There was no activity at the table. At 9:28 AM a staff put a wooden block toy in front of her, but she did not do anything with it. At the end of the observation Staff G was interviewed and said the purpose of the activity was socializing, learning shapes and colors and for interaction.</p> <p>Review on 3/9/15 at 10:00 AM of Resident #11 's record revealed she had moved to Percival House on 1/28/15 from 1030 Quinault Court House in a separate ICF/IID facility at Rainier School.</p> <p>On 3/10/15, Staff II was interviewed with Resident #11 's record available. He revealed Resident #11 was fairly new to Percival House having moved there from another house at Rainier School in a different ICF/IID facility. He stated her 30 day Individual Habilitation Plan meeting had been held 2/26/15 and that there were some changes but for the most part her plan was quite similar to the 12/2/14 IHP from 1030 QC House. He stated staff were still getting to know her.</p> <p>Resident #4</p> <p>1. On 3/3/15 from 10:15 AM to 10:38 AM, Resident #4 was observed seated at a table in the living room area of 2010B House. Resident #4 was seated in a wheelchair that was tilted back. Staff E played bingo for the Residents. Staff E spun the cage with the bingo numbers, told the Residents if they had a match, and then placed a marker on their card as needed. At approximately 10:30 AM, Staff F got a giant " Connect Four " game and placed a piece into Resident #4 's hand, with difficulty, and then attempted to have Resident #4 put the piece into the game board. She did not let go of the piece readily. Only 1 piece was attempted. At the end of the observation, when interviewed about the purpose of the activity, Staff F stated it was to</p>	W 196			

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W 196	Continued From page 29 help loosen her up. 2. On 3/3/15 from 5:18 PM to 5:40 PM, Resident #4 was seated in her wheelchair in the living room of her home. She was one of three Residents sitting in wheelchairs near the table where Staff G was playing a game called " Sharp Shooters " with them. The game involved throwing a number of dice onto a board and then making a determination as to where to place the dice on the game card if matches occurred. Initially Staff G was doing all of the game activities herself. Later, as the surveyor approached and asked about the game, Staff G began " putting " the dice near the Residents hands, or attempting to have the Residents hold the dice before throwing them onto the board. At the end of the observation when interviewed, Staff G said the purpose of the activity was to get them involved. 3. On 3/4/15 from 9:20 AM to 9:51 AM, Resident #4 was observed in her bedroom. She was seated in her wheelchair in the middle of her bedroom and there was music playing and a fan blowing on her. At the end of the observation, Staff J was interviewed and revealed having the fan blowing on her helped relax her. 4. On 3/5/15 from 9:00 AM to 10:10 AM, Resident #4 was observed in her home and then later in an activity room. At the start of the observation, Resident #4 was in a peer ' s bedroom in front of the TV. Another Resident was in the room as well. At 9:12 AM a staff brought her out into the living room and put her tennis shoes on. The TV was on but Resident #4 was far away from it and other Residents were blocking her view. At 9:18 AM a staff took her into the bathroom and she was in the bathroom for a total of 25 minutes. After coming out of the bathroom, she was taken to a large room in the same building where there was an activity to	W 196			

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W 196	<p>Continued From page 30</p> <p>make a clover for St. Patrick 's Day out of colored paper. Resident #4 was not able to cut the paper or fasten it together. The activity was performed by the staff. At the end of the observation, Staff L was interviewed and revealed Residents are chosen to come to the arts and crafts room based on who they think would benefit. Staff L said was directed to take Resident #4 to the activity that day.</p> <p>5. On 3/6/15 from 10:08 AM to 10:29 AM Resident #4 was observed in the activity room where a painting activity occurred. Resident #4 was observed with a baseball-style cap which was low down on her forehead partially obstructing her ability to see outward. Staff O painted the picture for Resident #4. Staff O was interviewed at the end of the observation and revealed the purpose of the activity was for engaging and socializing.</p> <p>Review on 3/6/15 of Resident #4 's record revealed her IHP dated 2/6/15 stated her long range training goal as " [Resident #4 's name] will maintain her overall range of motion through completion of training objectives in the areas of dressing, facewashing, dining, toothbrushing and choicemaking by 2017. "</p> <p>Interview on 3/9/15 at 3:25 PM with the QIDP, with Resident #4 's record available, verified a main focus of Resident #4 's training was to maintain her range of motion. She verified that many of the activities observed by the Surveyor did not have staff focusing on the Resident #4 's range of motion.</p> <p>Resident #10</p> <p>1. Observation was initiated at 7:00 AM on 3/3/15 in Naches House. At 7:32 AM, Resident #10 was seated at the dining table eating breakfast. At 8:10 AM, Resident #10 was observed sitting in her rocking chair holding a piece of fabric with</p>	W 196			

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W 196	<p>Continued From page 31</p> <p>textured items attached. House staff referred to this item as a texture apron. At 8:15 AM, Staff DD asked Resident #10 how she was doing and at 8:24 AM, Staff EE asked Resident #10 how she was doing. At 8:37 AM, Staff EE asked Resident #10 if she wanted to go join the activities in the other room then without waiting for a response from Resident #10, he walked over to two other non-sampled residents. Resident #10 remained seated in her rocking chair. Between 8:10 AM and 9:00 AM when the observation ended, there were no activities in which Resident #10 was involved in an active treatment program intended to teach skills or increase independence.</p> <p>2. Observation was initiated at 3:07 PM on 3/3/15 in Naches House. At that time, Resident #10 was sitting in her rocking chair with no activities. Four other non-sampled residents were also sitting in the same living room area without any activities. At 3:10 PM, Staff FF began asking if residents in the living room area if they wanted to sit outside in the backyard. Resident #10 went outside and came back inside at 3:11 PM. At that time, Staff FF assisted Resident #10 with putting her coat on. Resident #10 walked outside for one more minute then came back inside the house and walked around the house until 3:22 PM when she sat down at a table which had soft blocks and magazines on it. There were no staff or other residents at the table and she did not engage with any items on the table. At 3:25 PM, Staff FF asked Resident #10 if she wanted to come to the other side of the house. At that time, Resident #10 was observed getting up from the table and walking around the house until 3:37 PM when she sat down in her rocking chair. At 3:43 PM, Staff FF cued Resident #10 to come to the table to have a drink alongside a non-sampled resident.</p>	W 196			

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W 196	<p>Continued From page 32</p> <p>Resident #10 walked to the table and at 3:45 PM Staff FF assisted Resident #10 with taking her coat off, which she had been wearing in the house since 3:11 PM. At 3:48 PM Resident #10 left the table and returned to her rocking chair where she remained at 3:54 PM when observation ended. The room temperature in the house was warm and no other staff or residents were observed wearing their coats indoors. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence during this period of observation.</p> <p>3. Observation was initiated at 10:25 AM on 3/4/15 in Naches House. Resident #10 was observed at that time sitting at the dining area table. Resident #10 was looking at her fingers and twiddling her thumbs, not engaging in the blocks, bead tracks, or magazines sitting on the table. At 10:28 AM Resident #10 walked towards the back of the house with an unknown nurse and returned to her rocking chair at 10:31 AM. Resident #10 remained in her rocking chair without any activities until 10:50 AM when Staff DD asked her if she wanted to wash her hands for lunch. Resident #10 was observed eating lunch for the duration of the observation which ended at 11:38 AM. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence.</p> <p>4. Observation was initiated at 3:55 PM on 3/4/15 in Naches House. Resident #10 was sitting in her rocking chair in the living room area holding her texture apron. At 4:15 PM, Staff GG cued Resident #10 to come to the dining room table for dinner. At 4:52 PM Resident #10 returned to her rocking chair after dinner and held her texture apron. No activities were offered. The</p>	W 196			

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W 196	Continued From page 33 observation ended at 4:54 PM. 5. Observation was initiated at 10:05 AM on 3/5/15 in Naches House. Resident #10 was sitting in the living room area in her rocking chair, holding her texture apron. Two other non-sample residents were also sitting in the same room with no activities. At 10:07 AM, Staff HH came in from the back yard and asked one of the non-sample residents if she would like to draw outside with chalk. No activity was offered to Resident #10. At 10:22 AM, Staff HH came in from outside and handed Resident #10 her texture apron which she had let go of. Resident #10 remained in her rocking chair without any activity until 10:56 AM at which time Resident #10 went to the bathroom to wash her hands for lunch with staff assistance. Resident #10 was not observed to be involved in an active treatment program intended to teach skills or increase independence during this 52 minute observation. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10's Individual Habilitation Plan (IHP), IHP CODE & Prob # 4015 T07 A stated given a gestural and verbal cue, Resident #10 will remain at an activity with her peers for 3 minutes. The objective was to teach Resident #10 to be able to regulate her anxiety during group activities. During the observations from 3/3/15 through 3/5/15, Resident #10 was asked one time on 3/3/15 by Staff EE if she wanted to join other residents in the other room for activities. At no other time were activities offered or suggested to Resident #10. The IHP stated praise is a great reinforcer for her, and she likes knowing she has done a good job. The IHP stated Resident #10 does seem to appreciate an occasional light pat/rub on her back or head from known staff. There were no observations of staff praising Resident #10 or	W 196			

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W 196	<p>Continued From page 34</p> <p>offering physical touch. Resident #10's IHP also stated with objective #2071 she will express her wants, needs, and negations using natural gestures as a way to teach appropriate ways of expressing her agitation and anxiety. It is noted in the IHP that Resident #10 will display increased anxiety by leaving an area. On 3/3/15 when Resident #10 walked around the house for a total of 22 minutes, there was no staff intervention or involvement in assisting Resident #10 to express her needs and desires.</p> <p>During an interview with Staff EE at 8:37 AM on 3/3/15, when asked about Resident #10's texture apron, he stated Resident #10 likes to manipulate things and she has had that behavior for 17 years. Staff II, the Qualified Intellectual Disability Professional (QIDP), was interviewed on 3/10/15 at 10:25 am. He stated staff may use Resident #10's anxiety as a reason not to interact with her, especially if there is an activity coming up within 30 minutes.</p> <p>Resident #5</p> <p>1. Observation on 3/2/15 at Buckley house between 10:55 AM and 11:33 AM revealed Resident #5 was sitting in the living area of the home buckled into a recliner. Resident #5 continuously handled two strings that were attached to a metal hook that was fastened to a piece of wood (knot board). A staff passed through the area and stated "are you threading your board?" At 11:03, Staff R was observed bouncing a ball to other residents who were seated in the same area. Staff R asked Resident #5 if she wanted to play ball. Resident #5 did not respond. (Resident #5 was observed to be [REDACTED])</p> <p>Interview with Staff R about the purpose of the ball activity revealed it was designed to "engage residents" and work on "motor skills".</p> <p>2. Observation on 3/2/15 at Buckley House</p>	W 196			

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W 196	<p>Continued From page 35</p> <p>between 3:45PM and 4:00pm revealed Resident #5 sat in a recliner with a seat belt around her waist. No staff interacted with her.</p> <p>3. Observation on 3/3/15 at Buckley House between 9:25 AM and 10:30 AM revealed Resident #5 was buckled into a recliner. She was handling the strings on the knot board. At 9:45 AM, Staff H tied the two strings into multiple little knots. Resident #5 manipulated the knots until the knots were undone. At 10:07 AM staff state to Resident #5 "I see you have undone your knots." There was no other type of staff interaction. Interview with a staff working in the area about the purpose of the activity revealed Resident #5 works on her fine motor skills.</p> <p>4. Observation on 3/3/15 at Buckley House between 3:20 PM and 4:20 PM revealed Resident #5 was seated in a wheelchair handling the strings on the knot board. At 3:25 PM Staff T noticed something on Resident #5's face and washed her face. At 3:27 PM Staff T handed Resident #5 a piece of cloth with strings attached to it. Resident #23 did not do anything with the cloth. At 3:44 PM Staff T tied knots in the strings attached to the knot board and handed the board to Resident #23. There was no other type of staff interaction.</p> <p>5. Observation on 3/3/15 at Buckley House between 5:10 PM and 6:20 PM revealed Resident #5 was buckled into her wheelchair handling the strings on the knot board. At 5:15 PM, Staff T took Resident #5 into her room to change her shirt. This took approximately 5 minutes. At 6:05 PM, Staff T tied the strings on the board for Resident #5 to undo and then he assisted her to put a coat on. Resident #23 sat in her wheelchair with her coat on, handling the strings on the knot board until she left with staff at 6:20 PM. Staff T was asked where Resident #5 was going. Staff T</p>	W 196			

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W 196	<p>Continued From page 36</p> <p>stated to "watch a video on Zumba at PAT headquarters."</p> <p>6. Observation on 3/4/15 at Buckley House between 9:55 AM and 11:25 AM revealed Resident #5 was buckled into a wheelchair at the dining room table handling the strings on the knot board. Staff P was in the dining area of the home. At 10:10 AM, Staff P placed her hands over Resident #5's hands and assisted Resident #5 to untie the knots. (Resident #5 was observed to be able to independently untie the knots on previous days) Interview with Staff P about the purpose of the activity, Staff P stated "texture" and that she can "independently thread the board and staff do not need to help her with that."</p> <p>7. Observation 3/5/15 at 7:45 AM revealed staff brought Resident #5 into the living area of the home. Staff M handed Resident #5 a cloth with strings on it and stated "here is your macramé." At 7:55 a staff asked Resident #5 where her board was. The same staff left the area and returned with the knot board, knotted the strings together and placed the board in front of Resident #5. At 8:15 AM staff pushed Resident #5 to dining room table.</p> <p>Review of the IHP dated 3/18/14 for Resident #5 revealed the interdisciplinary team met and determined the focus of Resident #5's active treatment plan should include decreasing self-injurious behavior and increasing her current levels of independence in personal care and daily living routines. . In addition Resident #5 has a "knot board that she uses from time to time."</p> <p>None of the state surveyors observations of Resident #5 appeared to be designed to increase current levels of independence in personal care and daily routine.</p> <p>Interview with Staff WW on 3/10/15 regarding the active treatment program for Resident #5</p>	W 196			

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W 196	Continued From page 37	W 196			
W 247	revealed the program included a tooth brushing program, sensory program, wet washcloth program and a calming preferred activity. Staff WW stated Resident #5 likes the "knot board." 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to allow two of 12 Sampled Residents (Resident #1 and #10) to manage their own food preferences and self-manage their daily routines. These failures prevented residents from exercising freedom of choice and self-regulation. Findings include: Resident #10 1. Observation was initiated at 10:50 AM on 3/2/15 in Naches House. At 11:00 AM, Staff UU offered Resident #10 a toasted cheese sandwich, beef barley stew, or a "ground sandwich." The staff member dished up beef barley stew, potato salad, and macaroni salad without Resident #10 responding or assisting, then served her a cut up cheese sandwich once Resident #10 sat at the table. At 11:15 AM Staff UU brought cake in bowls to Resident #10's table. At the table, with Resident #10 present, Staff UU asked Staff JJ if Resident #10 wanted whipped cream on her cake. Staff JJ said, "Oh probably." Staff UU proceeded to put whipped cream on Resident #10's cake without asking her if she wanted it. Resident #10 was observed during the meal time to eat independently with a spoon, yet at no time did Resident #10 use a spoon to self-serve her own meal.	W 247			

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W 247	<p>Continued From page 38</p> <p>a. During observation at 7:38 AM on 3/3/15, Staff UU served breakfast to Resident #10 without giving her a choice of a breakfast item or participating in self-management in serving her own meal. At 8:30 AM, Resident #10 was observed receiving her medications by Staff SS. Staff SS prepared Resident #10's medications by mixing them with food then spoon fed them to her. Resident #10 was not given the opportunity to hold the spoon to administer her own medications. At 11:10 AM during lunch, Staff UU held Resident #10's plate and dished up food while Resident #10 stood and watched. Resident #10 did not have a choice of food or have the opportunity to self-serve her meal. At 11:33 AM, Staff UU prepared cake muffins in individual serving bowls for the residents at the dining table. The staff member squirted whipped cream out of the can onto Resident #10's cake without giving her the option of choosing whether or not she wanted any.</p> <p>b. At 11:05 AM on 3/4/15, Staff UU brought Resident #10's mat, plate, and spoon to the table where Resident #10 was sitting down. The staff then carried the plate to the food service table while the named resident followed behind. Staff UU told Resident #10 what the food choices were then dished up the food on her plate. At 4:15 PM, Staff GG took the named resident's plate to the food service table by himself and dished up food on her plate before bringing it back to her. Resident #10 was not given an opportunity to choose what she wanted to eat or self-serve her own food during breakfast or lunch on this day. At 4:05 PM, Resident #10 did not participate in self-management of her medications. The nurse administering the medications mixed the medications with food then brought the medications to Resident #10</p>	W 247			

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W 247	<p>Continued From page 39</p> <p>and spoon fed them to her. There was no opportunity for Resident #10 to self-administer her own medications.</p> <p>c. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10's Individual Habilitation Plan (IHP), IHP CODE & Prob # 1001 T 01 C, stated given gestures and a verbal cue, [Resident #10] will use a utensil to feed herself, with an average score of 4.0 or greater for 6 consecutive months. Resident #10's was observed using a spoon to feed herself during meals.</p> <p>d. A joint interview on 3/10/15 at 10:25 am with Staff II and Staff KK revealed neither have witnessed Resident #10 ever participate in self-administration of her medication. When asked why Resident #10 does not take part in this activity, the QIDP stated Resident #10 flails her arms around which would possibly prevent her from getting her medications. The behavior of flailing arms around when receiving medications was not observed by the surveyor.</p> <p>Under letter "c" where record review is noted: Resident 10's Comprehensive Functional Assessment (CFA) dated 11/20/14 stated [Resident 10] made choices from what feels good for the moment or what will satisfy a basic need. For her to be able to make choices, the options had to be presented to her in concrete form; things she can see, feel, touch, or activities she is familiar with. Resident 1's CFA also stated she is able to follow simple one-step requests that are part of her daily routine and she is able to feed herself with a spoon.</p> <p>2. Observation on 3/3/15 at 11:00 AM during lunch meal, 3/4/15 at 4:00 PM during dinner meal and 3/9/15 at 11:00 AM during lunch, Resident #1 is observed eating his meal and when finished</p>	W 247			

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W 247	Continued From page 40 brings Resident #1 brings his dishes to the kitchen. Various staff escort Resident #1 back to the dining room table where Resident #1 remains seated until other residents are finished with their meal. Interview with Staff S on 3/10/15 acknowledged Resident #1 is limited in what he can do as facility staff need to be near him at all times due to Resident #1's known [REDACTED] behavior [REDACTED] item). Staff S acknowledged Resident #1 could do a lot more and has a boring life. Staff S acknowledged Resident #1 requires direct care staff to be near at all times and Resident #1's daily routine is driven by staff responsibilities not Resident #1's choice. Interview with Staff BB on 3/10/15 at 3:00pm acknowledged that staff do the best they can with available staff. Staff acknowledged Resident #1 will sit with them and Resident #1's activities are based on what staff needs.	W 247			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure individual program plans were consistently implemented for two of 12 Sampled Residents (Residents #6 and	W 249			

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W 249	Continued From page 41 #10). This failure prevented the residents from having an opportunity to learn skill development and work toward accomplishing their objectives. Findings include: 1. At 7:15 AM on 3/3/15, Resident #10 was seated at the dining room table. Staff UU picked up Resident #10's cup from the table, walked away from the table, poured juice into the cup, then brought the filled cup back to Resident #10. At 3:43 PM, Staff FF cued Resident #10 to sit down next to a non-sampled resident to get a drink. Staff FF got a cup from the shelf and brought it to Resident #10 at the table. At no time on this day was Resident #10 observed retrieving her cup from the place setting in the dining area where it is stored between meals. a. Observation at 11:05 on 3/4/15 revealed Resident #10 sat down for lunch and Staff UU retrieved Resident #10's cup from the place setting in the dining area and brought it to her at the table. Resident #10 was not provided the opportunity to pick up her cup. At 3:55 PM, when the surveyor arrived at Resident #10's home, her place setting, including her cup, was already set out on the dining table for dinner. b. Between 4:30 PM and 4:37 PM on 3/4/15, Resident #10 ate most of her dinner of mixed vegetables, ham, and macaroni and cheese with her fingers. At 4:35, staff cued her spoon. Resident #10 ate with her spoon for 10 seconds then resumed using her fingers. There were no other cues from staff. c. During observation at 8:30 AM on 3/3/15, Resident #10 received her medications from Staff SS when the staff pushed the cart towards the chair where Resident #10 was sitting. At 3:50 PM, Resident #10 received her medications from Staff PP. Staff PP prepared Resident #10's medications at the medication cart then brought	W 249			

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W 249	<p>Continued From page 42</p> <p>the cart to Resident #10 in her rocking chair. During both medication passes, each staff member spoon fed the medications to Resident #10. Neither time, Resident #10 was not called to come to the medication cart or given an opportunity to use a utensil to feed the medications to herself.</p> <p>d. Observation at 4:05 PM on 3/9/15 revealed Resident #10 received her medications from LPN2 TT after he pushed the cart to where Resident #10 was sitting. He then spoon fed the medications to her. There was no opportunity or cue for Resident #10 to come to the medication cart or participate by using a utensil to feed herself.</p> <p>e. Record review for Resident #10 was conducted on 3/10/15 at 2:00 PM. In Resident #10's Individual Habilitation Plan (IHP), dated 11/20/14 IHP CODE & Prob # 1001 T01 C, stated given gestures and a verbal cue, [Resident #10] will use a utensil to feed herself, with an average score of 4.0 or greater for 6 consecutive months. Her IHP CODE & Prob # 1005 T01 B/C stated given verbal and visual cues, [Resident #10] will indicate her desire for a drink by picking up her glass from her place setting in the dining room, with an average score of 6.0 or greater for 6 consecutive months. Record review of Resident #10's Service Plan Revision, approved on 12/29/14 found Prob #8052 which stated Resident #10 would come to the medication cart when her name was called.</p> <p>f. A joint interview on 3/10/15 at 10:25 am with Staff II and Staff KK revealed neither have witnessed Resident #10 ever participate in using a utensil in self-administration of her medication. Staff II reported Resident #10 flails her arms around which would possibly prevent her from getting her medications. This behavior was not</p>	W 249			

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W 249	Continued From page 43 observed by the surveyor. 2. Review of the Individual Habilitation Plan dated 7/14/14 revealed Resident #6's wheelchair should be used only when Resident #6 was unsteady or having difficulty walking. a. Observation at Buckley House on 3/2/15 at 10:55 AM revealed Resident #6 was sitting in an easy chair in the living area of the home. At 11:11, Staff M assisted Resident #6 from the recliner into a wheelchair. Staff M then pushed Resident #6 into the dining room. Staff M assisted Resident #6 from the wheelchair to the dining room chair. b. Observation at Buckley House on 3/3/15 at 3:20 PM revealed Resident #6 was sitting in a recliner chair in the living area of the home. At 4:15 PM, Staff M assisted Resident #6 from the recliner into a wheelchair. Resident #6 started self-propelling herself towards the dining area of the home. Staff stepped in and pushed her chair to the dining room table. Resident #6 was then assisted from the wheelchair to the dining room chair. c. The state surveyor asked Staff M why Resident #6 was never observed walking in her home. Staff M stated Resident #6 has an awkward gait and she and Staff P cannot assist her to walk. Staff M added that some of the male staff (who were larger in stature) could assist Resident #6 to walk around her home.	W 249			
W 301	483.450(d)(4) PHYSICAL RESTRAINTS A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints. This STANDARD is not met as evidenced by:	W 301			

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W 301	<p>Continued From page 44</p> <p>W301 - Based on observation, record review and interview the facility failed to ensure Residents were checked while being restrained either on a toilet, in dining room chair or in a recliner. This failure resulted in Residents being placed in restraints and left for long periods of time without staff ensuring residents were safe, comfortable, and if restraint needed to be released. Findings include:</p> <p>Dining Room Chairs Observation on 3/5/15 at Buckley house between 7: 10 AM and 7:48 AM revealed Resident #6 was seated in a dining room chair with a seat belt buckled around the middle of her chest. There were no staff in the room. Resident #6 sat upright in the chair, picking at her shirt, wiggling her feet and looking around. Resident #6 never tried to remove the restraint. At 7:48 AM a staff entered the dining room and pushed her chair up to dining room table. At 8:12 AM a staff dished Resident #6's breakfast into a bowl and Resident #6 started eating. At no time did staff check to ensure the restraint was fitted properly or if Resident #6 was comfortable. Record review on 3/9/15 of Resident #6's IHP dated 7/14/14 revealed the dining room chair restraint was to be used only when Resident #6 was eating. Interview with Staff Q on 3/11/15 about the use of the restraints in dining room chairs revealed the facility uses the seat belts that are attached to the dining room chairs as "positioning devices" and should only be used when eating.</p> <p>Toilet Seat Restraints Observation between 3/2/15 and 3/11/15 at Buckley house revealed Resident #30 capable of walking, sitting and standing independently. Observation on 3/5/15 at Buckley house revealed</p>	W 301			

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W 301	<p>Continued From page 45</p> <p>an Adult Training Program staff took Resident #30 into the bathroom at 7:50 AM. The ATP staff came out of the bathroom. The ATP staff started assisting residents with breakfast. The ATP did not check on Resident #30. At 8:17 AM, the surveyor asked the ATP staff to produce the toilet support log for Resident #30. The ATP staff went to the bathroom and gave the restraint log to the surveyor. The ATP staff had not entered the time she put Resident #30 on the toilet. Resident #30 sat, restrained on a toilet for 27 minutes until the surveyor intervened.</p> <p>Review of the toilet support log for 3/5/15 revealed staff had not documented when Resident #30 was put on the toilet, when, or if she had been checked.</p> <p>Review of the facility's policy title SOP 3.13 revealed residents placed in a "toilet support" device will be monitored at a minimum of every ten minutes.</p> <p>Interview with Staff M on 3/4 /15 revealed Resident #30 needed to be kept on the toilet until staff could assist her to clean herself properly.</p> <p>Recliner Restraints</p> <p>1. Observation of Devenish living rooms (A and B side of the house) on 3/2/15 at 10:50 AM revealed a number of recliners with seatbelts. On 3/3/15 at 4:50 PM following a dinner meal, Staff RR was observed bringing Resident #29 into the living room. Staff RR assisted Resident #29 into recliner and restrained him using the seatbelt. Staff RR then returned to the dining room area to sweep the floor. Resident # 29 was observed squirming in the recliner in an attempt to get up. Observation on 3/9/15 at 10:45 AM and 3/5/215 at 8:00 AM Resident #26 and Resident #27 are observed restrained in a recliner in the living room using a seatbelt.</p> <p>Interview with Staff Y at 8:00 AM on 3/5/15</p>	W 301			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2015
NAME OF PROVIDER OR SUPPLIER RAINIER SCHOOL PAT A			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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 301	Continued From page 46 acknowledged Resident #26 is restrained in the recliner for safety reasons and to prevent her from walking around so she doesn't roam. Staff Y acknowledged Resident #26 used to hate the use of the seatbelt but now is getting used to them. When asked why Resident #27 was restrained in the recliner with a seatbelt, Staff Y acknowledged she didn't know exactly why then reported use of seatbelts were always for safety. Interview with Staff Z on 3/4/15 at 10:45 AM acknowledged the use of seatbelts were for safety and for resident protection. Staff Z revealed Resident #26 and Resident #27 were not stable walking and would hurt themselves. Record review of Individual Habilitation Plan (IHP) for Resident #26 dated 10/16/14; Resident #27 dated 8/5/14 and Resident #29 dated 9/18/14 revealed use of adaptive/mechanical support were considered restrictive as the resident cannot remove them and with such equipment would be at risk of injury. Interview with Staff S on 3/10/15 at 2:50 PM acknowledged staff did not track how long residents were kept seatbelted into recliners.	W 301			
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 12 Sample Residents (Resident #4) received nursing care as directed by the Physician when a nurse administered Resident #4 seven consecutive vaginal douches to clear fecal material. This failure resulted in	W 339			

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W 339	Continued From page 47 Resident #4 receiving treatment not ordered by the Physician. Findings include: Review on 3/6/15 of Resident #4 's record revealed an entry in her Health Progress Notes, dated 1/23/15, which indicated Resident #4 had received 7 vaginal douches in an attempt to clear fecal material from her vagina. A Physician 's Order dated 10/10/14 revealed she was to have a vaginal douche. Review on 3/6/15 of Resident #4 's record revealed she was diagnosed with [REDACTED], was confined to a wheelchair, and was [REDACTED]l. Interview on 3/10/15 with Staff AA revealed Resident #4 wears an Attends (protective undergarment). She often makes back and forth motions with her pelvic area while in her wheelchair and that this leads to fecal matter getting into her vaginal area. She verified the douche was to remove the fecal matter. Staff AA also verified Staff XX had not followed the Physician 's orders when 7 douches were completed.	W 339			