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

PRINTED: 01/25/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 50G050 | | C 01/07/2016 |

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) | ID 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<br><br>This report is a complaint investigation for #3175398 conducted on 11/10/15 through 1/07/16 at Rainier School PAT A. Failed provider practice was identified.<br><br>The survey was conducted by:<br>Shana Privett<br><br>The survey team is from:<br>Department of Social & Health Services<br>Aging & Long Term Support Administration<br>Residential Care Services, ICF/IID Survey and Certification Program<br>PO Box 45600, MS: 45600<br>Olympia, WA 98504<br><br>Telephone: (360) 725-2405 | W 000 | The 2010B IDT requested and received OT/PT assessment for client #1; held an AD-hoc meeting to discuss assessment recommendations with guardian involvement; and received guardian consent and HRC approval for using any restrictive procedures.<br>**Person responsible:** QIDP/DDA1<br>**Monitor:** DDA2 | Complete |
| | | | PAT A will review all serious injuries that have occurred since April 2015. For any serious injury that required an Ad-hoc meeting, PAT A management will review the Ad-hoc meeting records to ensure any restrictive procedures were assessed by a therapeutic professional, guardians were notified, and guardian consent and HRC approval was obtained for using any restrictive procedures. If the AD-hoc did not address any of the specific components listed above, an AD-hoc will be held to specifically to address the missing component.<br>**Person responsible:** QIDP/DDA1<br>**Monitor:** DDA1/DDA2 | 3/1/16 & ongoing |
| W 159 | 483.430(a) QIDP<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.<br>This STANDARD is not met as evidenced by:<br>Based on observations, record review and interview, the Facility's Qualified Intellectual Disability Professional (QIDP) failed to protect Client #1's rights when she allowed restraints to be implemented without due process. Restrictive measures were implemented which resulted in Client #1 being restrained in a variety of situations (wheelchair, toilet, recliner, dining chair and shower chair) with a seatbelt without following due process. This failure resulted in Client #1 not receiving required assessments, having his rights violated and no one to advocate for him. | W 159 | Physicians will receive training to include the reason(s) for devices when ordering restrictive procedures; end dates for use of restrictive devices and the referral process for therapeutic professional assessments.<br>**Person responsible:** Medical Director<br>**Monitor:** DDA2 | 3/1/16 & ongoing |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 50G050 | | C 01/07/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RAINIER SCHOOL PAT A | 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 159 | Continued From page 1<br>Findings include:<br><br>Observation on 1/7/16 at 1:35 PM at 2010 B Quinault Court revealed Client #1 sitting in a reclining chair with a seat belt secured on his lower abdomen. Near the Client in the living room was his personal wheelchair that was equipped with seatbelts.<br><br>Record review on 1/7/16 at 10:55 AM revealed Doctor Orders were written on 12/26/15 at 10:00 AM for Client #1 to use a seat belt at all times when in a wheelchair to prevent re-injury of his fractured clavicle. The Doctor then wrote orders on 12/28/15 for Client #1 to use a seat belt on shower chair, recliner, wheelchair and toilet. There was no expiration dates with the orders and the Doctor did not write the order for restraints for the purpose of healing only. An AD HOC dated 12/28/15 directed the use of a seatbelt for Client #1 due to several falls, including a fall from the toilet. The AD HOC reinstated seatbelts on the toilet, recliner, wheel chair, dining chair and shower chair and stated that Client #1 was unable to disengage a seatbelt. The AD HOC did not include any requests for assessments from other therapeutic professionals for the use of restraints, there was no time frame for the use of the restrictive measures (other than to be released every 2 hours), there was no alternative options offered and there was no approval from the Human Rights Committee to implement restrictive procedures on Client #1. There was no evidence of guardian notification.<br><br>Interview on 1/7/16 at 11:30 AM with Staff A and Staff B verified Client #1 had seatbelts on his wheelchair, recliner, shower chair, toilet and | W 159 | PAT A QIDP's will receive training on obtaining required assessments prior to or at the AD-hoc meeting. They will also receive training on how to ensure clients rights are upheld with due process, HRC approval, and guardian notification/consent for implementation of restrictive devices.<br>**Person responsible:** DDA1/DDA2<br>**Monitor:** DDA2<br><br>DDA1 will monitor all AD-hocs to ensure that required assessments are obtained prior to or at the AD-hoc meeting when requesting the use of restrictive procedures; that the AD-hoc meetings include guardian involvement whenever possible; that HRC approval and guardians are notified, and consent is obtained to ensure that client rights are protected and due process occurs. When reviewing the AD-hoc and the components list above are not present, the DDA1 will follow-up with the QIDP to ensure compliance.<br>Rainier School QA will monitor serious injuries, use of restrictive procedures to ensure client rights are not violated on a regular basis and provide data to Program Area Directors.<br>**Person responsible:** DDA1<br>**Monitor:** DDA2 | 3/1/16 & ongoing<br><br>Ongoing<br><br>Ongoing |



RG.

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

PRINTED: 01/25/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 50G050 | | C 01/07/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RAINIER SCHOOL PAT A | 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 159 | Continued From page 2 dining chair since 12/28/15 but this was not approved by the Human Rights committee. | W 159 | | |