

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

PRINTED: 12/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>11/14/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD</b> <b>BUCKLEY, WA 98321</b>		
(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}	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of a POST visit for an Annual Recertification Survey conducted at Rainier School PAT C on 11/13/13 and 11/14/13. A sample of 10 residents was selected from a census of 99 residents.</p> <p>The survey was conducted by: Janette Buchanan, R.N., B.S.N.</p> <p>The survey team is from: ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600</p> <p>Telephone: (360) 725-2405 Fax: (360) 725-2642</p>	{W 000}			
{W 322}	<p><b>483.460(a)(3) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure Annual Health Care Assessments were completed for 2 of 10 sample residents (Resident #2 &amp; #7). Failure to have Annual Health Care Assessment placed residents at risk of</p>	{W 322}		<p><b>RECEIVED</b></p> <p><b>DEC 17 2014</b></p> <p>DSHC-ADSA Residential Care Services ICF/MR Program</p>	

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.

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{W 322}	<p>Continued From page 1 unidentified medical issues and further deterioration of Resident #2 &amp; #7 's health.</p> <p>Findings include:</p> <p>On 11/13/13 and 11/14/13 facility records revealed that Resident #2 &amp; #7 did not have updated Annual Health Care Assessments. Resident #2 's file revealed that the Assessment was due 01/03/13 and Resident #7 's Assessment was due 01/25/13. Interview with Staff B revealed that Resident #2 last had an Annual Health Care Assessment completed 04/24/12 and Resident #7 's last assessment was 08/30/12.</p> <p>Interview with facility assistant Superintendent, PAT C nursing supervisor and PAT C assistant director revealed that they were unaware of any assessments that were not completed. Nursing supervisor stated that the facility had gone through and noted when all the assessments were due and the list was given to the physician in charge of PAT C.</p>	{W 322}	<p>W 322 Physician Services</p> <p>Rainier School will consolidate physician services into a centralized location in order to help ensure adequate Physician coverage and timely assessments Of residents needs and use newly developed tracking system For clinic nurses and PCP to use when completing</p> <p>AHCA</p> <p>PERSON RESPONSIBLE: PCP</p> <p>MONITOR: ADMIN</p> <p>09/13/13</p> <p>Resident 2 and 7 will have updated health care <i>resident 2 completed 8/20/13</i> Assessments completed</p> <p>PERSON RESPONSIBLE: PCP</p> <p>MONITOR: CLINICAL DIRECTOR</p> <p>12/30/13</p> <p>Rainier School hired another physician to assist In completing duties</p> <p>PERSON RESPONSIBLE: CLINICAL DIRECTOR</p> <p>MONITOR: SUP</p> <p>11/01/2013</p>		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 50G047	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/14/2013
Name of Facility RAINIER SCHOOL PAT C		Street Address, City, State, Zip Code RYAN ROAD BUCKLEY, WA 98321

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>W0104</u> Reg. # <u>483.410(a)(1)</u> LSC _____	Correction Completed <u>09/13/2013</u>	ID Prefix <u>W0112</u> Reg. # <u>483.410(c)(2)</u> LSC _____	Correction Completed <u>09/17/2013</u>	ID Prefix <u>W0247</u> Reg. # <u>483.440(c)(6)(vi)</u> LSC _____	Correction Completed <u>09/17/2013</u>
ID Prefix <u>W0339</u> Reg. # <u>483.460(c)(4)</u> LSC _____	Correction Completed <u>09/17/2013</u>	ID Prefix <u>W0455</u> Reg. # <u>483.470(l)(1)</u> LSC _____	Correction Completed <u>09/17/2013</u>	ID Prefix <u>W0473</u> Reg. # <u>483.480(b)(2)(ii)</u> LSC _____	Correction Completed <u>09/30/2013</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>Linda Ramirez</u>	Date: <u>12/02/13</u>	Signature of Surveyor: <u>Janette Buchanan BSN</u>	Date: <u>12/2/13</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>7/18/2013</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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W 000	INITIAL COMMENTS  This report is a result of an Annual Recertification Survey conducted at Rainier School - PAT C on 07/14/13, 07/15/13, 07/16/13, 07/17/13 and 07/18/13. A sample of 10 residents was selected from a census of 101. An expanded sample included 9 current residents.  The survey was conducted by:  Claudia Baetge Christina Borchardt Terry Patton Penelope Rarick  The survey team is from:  State of Washington Department of Social and Health Services Residential Care Services Administration ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642	W 000		
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 and interviews, the facility failed to ensure a well repaired and maintained environment which was free from safety hazards for 1 of 7 houses and provide toilet paper for 2 of 7 houses. This failure to provide a well repaired	W 104	W 104 GOVERNING BODY  Gait/fence repairs were completed. Rusty nails were removed. Drain spout was replaced.  PERSON RESPONSIBLE: ACM  MONITOR: DDA2  09/13/13	

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

*[Handwritten Signature]*

TITLE

*[Handwritten Title]*

(X6) DATE

*[Handwritten Date]*

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W 104	<p>Continued From page 1 and maintained environment placed residents at risk for injury. The lack of toilet paper prevented residents from maintaining good hygiene and personal dignity following toileting.</p> <p>Findings include:</p> <p>All observations and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated.</p> <p>Facility Exterior-Safety Hazards Observations at House 2025 revealed:</p> <ol style="list-style-type: none"> <li>1. South side fence had 2 gated sections removed from posts that were leaning against main fence exposing protruding rusty screws and nails at hinges.</li> <li>2. North side yard had gate with two rusty nails protruding from gates outer door edge.</li> <li>3. Downspout on the corner of the house was broken and exposing sharp metal edges.</li> </ol> <p>Interview with 2025 facility staff revealed south side gated sections had been broken since moving into house in February 2013. Staff was not aware if a work order had been submitted for repair of broken fence gates.</p> <p>Facility Interior Observations at House 1030 revealed no toilet paper in bathrooms A13 and B13 on 07/14/13 at 3:40PM (for approximately 2 hours). Observations at House 2015 revealed no toilet paper in B side hallway bathroom on 07/14/13 at 3:30pm and 07/15/13 at 10:00am. Interview with House 2015 staff on 7/14/13 indicated residents use Attend Wipes in place of toilet paper. The Attend Wipes were located approximately 4 to 5 feet from toilet, out of reach of residents sitting on the toilet. However, interview with another House 2015 staff on</p>	W 104	<p>Rainier School staff will monitor their immediate work area for potential safety hazards and submit work requests to rectify deficiencies as they arise.</p> <p>PERSON RESPONSIBLE: ACM</p> <p>MONITOR: DDA2</p> <p>On-going</p> <p>Rainier School staff will regularly monitor bathrooms on the house once per shift to ensure an adequate supply of toilet paper and other necessary hygiene products.</p> <p>PERSON RESPONSIBLE: ACM</p> <p>MONITOR DDA2</p> <p>On-going</p> <p>ACMs will complete monthly environmental observation checklist to the PAT ensuring that these are done.</p> <p>PERSON RESPONSIBLE: ACM</p> <p>MONITOR: DDA1</p>		

*ACM*  
*9/5/13*

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W 104	Continued From page 2 07/15/13 acknowledged toilet paper should have been available to residents in B side bathroom, next to the toilet.	W 104			
W 112	483.410(c)(2) CLIENT RECORDS  The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.  This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to secure resident health care records for 1 of 1 sampled resident (Resident #4 ) and 9 of 9 expanded sample residents ( Residents #11, # 12, #13, #14, #15, #16, #17, #18 and # 19). This failure created a potential for loss/misplacement of medical records and violation of residents ' rights to keep their medical information confidential.  Findings Include:  On 07/17/13 observations on House 1030 at 8:25AM and 11:30PM, revealed resident health care records were left unsecured on the counter of the medication administration area where they could have been observed by residents or visitors. The medication area is a common area in the house and is accessible by residents and visitors. There were no staff in the medication administration area during the observations.  Nursing Orders and Treatment Record for Resident #4 and Resident #17 were face up on the counter of the medication administration area. Lying next to these documents was a manila file folder that contained the following health care	W 112	W 112 CLIENT RECORDS  Rainier School will provide grounds-wide training to all nursing staff regarding current HIPAA requirements to securely maintain all sensitive and confidential client records.  PERSON RESPONSIBLE: RN4  MONITOR: DIRECTOR OF NURSING  09/17/13  RN4 will complete weekly observations  To maintain compliance of HIPAA regulations.  PERSON RESPONSIBLE: RN4  MONITOR: DDA2  09/17/13		

*AM*  
9/5/13

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W 112	<p>Continued From page 3</p> <p>records for residents who lived in House 1030:</p> <p>Resident #4: Dental Assessment, dated 07/9/13 UA Request, dated 06/06/13</p> <p>Resident #11: ER Visit Summary, dated 06/30/13 Lab Report, dated 07/01/13</p> <p>Resident #12: Podiatry Report</p> <p>Resident #13: Annual Physical, dated 06/20/13</p> <p>Resident #14: Specimen Report, dated 07/01/13</p> <p>Resident #15: Routine Medical Re-Evaluation, dated 07/01/13</p> <p>Resident #16: Optometry Report, dated 06/17/13 Specimen Report, dated 07/02/13 ER Report, dated 07/02/13</p> <p>Resident #17: Dental Annual Assessment, dated 07/09/13</p> <p>Resident #18: Annual Physical, dated 06/27/13</p> <p>An Annual Physical, dated 05/31/13, for Resident #19 was also found in the manila file folder in the medication administration room of House 1030. Resident #19 resides in House 2035. Interview with the facility RN4 acknowledged all health care records should be secured and kept</p>	W 112			

*AM*  
*9/5/13*

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W 112	Continued From page 4 confidential by placing records in a locked drawer, cabinet or filing them in the resident ' s medical chart.	W 112			
W 247	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 observations and interviews, the facility failed to offer residents of three houses (House 1030, 2005 and 2015) a choice of food options during three dinner meals and two lunch meals. This failure resulted in residents not being allowed to exercise choice and self-management during meals.  Findings include:  Observation of House 1030 dinner on 07/14/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 1030 staff revealed they did not prepare or offer a food alternative to residents, but could provide peanut butter sandwiches if residents asked for an alternative to the food being served.  Observation of House 2015 dinner on 07/14/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 2015 staff revealed that the alternative food choice was ravioli. The can of ravioli was not opened, nor offered to the residents.	W 247	W 247 INDIVIDUAL PROGRAM PLAN  Rainier School will develop a grounds-wide procedure for meal preparation and serving responsibilities, which will include specific instructions on how to provide meal choices to the residents.  PERSON RESPONSIBLE: DDA2  MONITOR: ASSISTANT SUPERINTENDENT  09/13/13  ACM's will complete two monthly meal time observations that monitor the procedure  PERSON RESPONSIBLE: ACM  MONITOR: DDA2  09/17/13		

*ACM*  
*9/5/13*

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W 247	Continued From page 5 Observation of House 2005 lunch on 7/15/13 revealed staff did not offer residents an alternative to the food items that came from the main facility kitchen. Interviews with House 2005 staff revealed they did not prepare or offer a food alternative since they knew the meal provided by the main kitchen was a favorite of the residents.  Observation of House 2005 and 1030 dinner on 07/16/13 revealed staff did not offer an alternative to the food items that came from the main facility kitchen. During interviews, staff on House 2005 revealed they did not have time to prepare an alternative food item and they were unable to provide food choices to the residents.	W 247			
W 322	483.460(a)(3) PHYSICIAN SERVICES  The facility must provide or obtain preventive and general medical care.  This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an Annual Health Care Assessment was completed for 1 of 10 sampled residents (Resident #4). Failure to have an Annual Health Care Assessment placed resident at risk of unidentified medical issues and further deterioration of Resident #4 's health.  Findings Include:  All record reviews and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated.  Record review reveals Resident #4 has a <b>3</b>	W 322	W 322 PHYSICIAN SERVICES  Rainier School will consolidate physician services into a centralized location in order to help ensure adequate physician coverage and timely assessments of resident needs.  Resident 4 will have his annual physical completed  Develop tracking sheet for use at the clinic in excel  For clinic nurses and doctors to use when  completing an AHCA  PERSON RESPONSIBLE: CLINICAL DIRECTOR  MONITOR: QA DIRECTOR	09/13/13	

*sem*  
9/5/13

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W 322	Continued From page 6 	W 322			
W 339	Record Review revealed Resident #4 's last Annual Health Care Assessment was completed on 04/06/2012.  Interviews revealed Resident #4 was inadvertently missed when scheduling Annual Health Care Assessments for his house. <b>483.460(c)(4) NURSING SERVICES</b>  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 reviews and interviews, the facility failed to follow the nursing care plan and report abnormal glucose values to the physician for 1 of 1 sampled residents (Resident #4), who is diabetic. Failure to follow the nursing order placed resident at risk of having blood glucose related complications and further deterioration of Resident #4 's health.  Findings Include:  All record reviews and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated.	W 339	<b>W 339 NURSING SERVICES</b>  All Registered Nurses (RN) will receive training on updating nursing care plans and nursing orders on their assigned caseload based on current resident need.  RN4 will review at QA IDT quarterly review  Sampled clients PERSON RESPONSIBLE: RN4  MONITOR: DIRECTOR OF NURSING		

*Handwritten:*  
9/5/13

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W 339	Continued From page 7  Review of Resident #4 's Nursing Care Plan revealed the Nursing Problem/Diagnosis - Diabetes-Hyperglycemia. Review of Resident #4 's Nursing Order and Treatment Record (March, April, May, June and July 2013) reveals the order to report blood sugar <50 and >250 to MD or PAC. Review of Resident #4 's daily Diabetes Mellitus Blood Glucose and Insulin Monitoring form revealed the following glucose values: 03/23/13 - 41; 03/28/13 - 256; 4/08/13 - 347; 07/6/13 - 258; 07/11/13 - 325.  Record review revealed staff failed to notify the doctor when the values were outside of the medical perimeters outlined in the nursing orders.  During interviews, nursing staff acknowledged the failure to follow the nursing care plan orders.	W 339	All Licensed Practical Nurses (LPN) will receive training on implementing all nursing orders on their assigned caseload.  RN4 will complete weekly observations for compliance.  PERSON RESPONSIBLE: RN4  MONITOR: DIRECTOR OF NURSING	09/17/13	
W 455	483.470(l)(1) INFECTION CONTROL  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  This STANDARD is not met as evidenced by: Based on observations and interviews, facility failed to observe infection control practices. Resident hygiene items, food service, dishes/flatware handling and facility laundry were done in a manner which will cause cross-contamination. These failures placed residents at risk of illness due to communicable diseases.  Findings include:	W 455	W 455 INFECTION CONTROL  All AC staff will receive continuing and on-going training on appropriate infection control procedures, to include proper maintenance of personal hygiene equipment/products and the proper use of gloves and other personal protective equipment in the prevention of cross-contamination.  Infection Control will submit quarterly Review of infection control issues noted on each house		

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9/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD BUCKLEY, WA 98321</b>		
(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)	(X6) COMPLETION DATE	
W 455	Continued From page 8  All observations and interviews were conducted on 07/14/13 to 07/18/13 unless otherwise stated.  At House 2005 4 of 8 razors and 2 hairbrushes were co-mingled in a drawer in bathroom A13. The bottom of the drawer was covered in loose facial hair from the razors.  At Houses 1030 and 2005 staff wore gloves when using hand-over-hand technique to assist residents with serving their food. Staff then continued to wear the same gloves when they handled hamburger buns, wiped residents' mouths, removed spilled food from a resident's laps, touched clean and dirty plates, touched clean and dirty utensils.  At House 2035 Staff A was observed touching a resident's shoulder, a resident's hand, countertops, cabinets and her hair while wearing gloves. Then, while wearing the same gloves, the staff removed clean dishes and utensils from the dishwasher and touched areas where food would come in contact with the dishes and utensils.  On 07/18/13 staff working in the facility laundry were observed loading soiled linen and clothing into front loading washing machines. When loading the washing machines the soiled items and/or soiled gloves worn by staff came in contact with the inside of the washing machine door, the seal around the washing machine door, the door handle, the front of the washing machine and the control knobs. Staff did not use any disinfectant to sanitize any areas of the washing machines which may have been contaminated	W 455	All laundry staff will receive training on infection control techniques to include avoidance of cross-contamination and disinfection of all appropriate surfaces.  To the program area director  PERSON RESPONSIBLE: Infection Control  MONITOR: ACM /DDA2  09/17/13  Infection control nurse will complete quarterly observations of the laundry area to ensure techniques of cross contamination are being used and submit to all program areas.  PERSON RESPONSIBLE: LAUNDRY SUPERVISOR/INFECTION CONTROL NURSE  MONITOR: DDA2  08/20/13		

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9/5/13

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

PRINTED: 08/07/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2013</b>
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W 455	Continued From page 9 when loading soiled clothing and linens. When removed from the washing machines, the clean clothing contacted the contaminated door rim and front of the washer. Staff wearing clean gloves while removing the clean linen and clothing, touched the contaminated areas of the washing machine. On 07/18/13, Staff B stated the laundry staff believed when the clothes washer was turned on it cleaned the rim of the machine of contaminates. Staff were unaware of the need to disinfect the contaminated door rim, the door seal and outside surface of the clothes washer.	W 455			
W 473	483.480(b)(2)(ii) MEAL SERVICES  Food must be served at appropriate temperature.  This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to maintain the appropriate food temperature on House 1030, 2005, and 2015. This failure to serve food at the appropriate temperatures resulted in residents being served food at inappropriate temperatures creating potential for foodborne illness. This failure also denied residents their dignity in being served meals at appropriate temperatures.  Findings include:  Observation of 2015 house dinner meal on 07/14/13, revealed food was served at the following temperatures: beef patty 92°, tater tots 91° and vegetables 96°. In addition, two special diet order meals in individual containers were served at the following temperature. Meal 1: beef patty 75°, tater tots 80°, and vegetables 80°. Meal 2: beef patty 80°.	W 473			

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9/5/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/18/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD BUCKLEY, WA 98321</b>		
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W 473	<p>Continued From page 10</p> <p>Observation of 1030 house dinner meal on 07/14/13, revealed milk was served at 54.1°.</p> <p>Observation of 2005 house lunch and dinner meal on 07/16/13, revealed the food was served at the following temperatures: cooked carrots 120°, coleslaw 58°, beef patty 120° and milk 60°.</p> <p>Interviews with staff on House 1030 and 2005 revealed staff were unaware of food temperature guidelines. When asked, staff were unable to report what holding temperatures should be for hot and cooled food items. Staff from both houses reported that it was a challenge to keep food cool during the hot weather. Staff also had difficulty understanding the process for correctly taking food temperatures.</p> <p>The USDA guidelines recommend food must be reheated to 165° Fahrenheit or above and held above 140° Fahrenheit unit served, in order to destroy bacteria that can cause food borne illness. Cold food items should be held and served at 45° or cooler.</p>	W 473	<p>W 473 MEAL SERVICES</p> <p>Rainier School will develop a grounds-wide procedure for meal preparation and serving responsibilities that will detail how staff are to monitor and maintain optimum food temperatures for both hot and cold foods.</p> <p>PERSON RESPONSIBLE: DDA2</p> <p>MONITOR: ASSISTANT SUPERINTENDENT</p> <p>Rainier School will order appropriate equipment to ensure proper monitoring and maintaining of optimum food temperatures (i.e., thermometers, hot and cold serving containers).</p> <p>PERSON RESPONSIBLE: DDA2</p> <p>MONITOR: ASSISTANT SUPERINTENDENT</p> <p>09/30/13</p> <p>ACM's will complete two monthly meal time observations that monitor the procedure</p> <p>PERSON RESPONSIBLE: ACM</p> <p>MONITOR: DDA2</p>		

*ACM*  
9/5/13