

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	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 a result of a Recertification Survey conducted at Rainier School Pat C from 11/16/15 through 11/20/15. A sample of 10 Clients was selected from a census of 95 clients. The expanded sample included 3 current Clients.  The survey was conducted by: Gerald Heilinger Terry Patton Shana Privett Justin Smith Jim Tarr  The Survey Team is from: ICF/IIID 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- 725-3215	W 000			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS  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. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to have the phone number for the Complaint Resolution Unit (CRU) telephone number posted in a common area in 4 of the 8	W 125			12/18/15

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

TITLE

(X6) DATE

12/18/2015

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.

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	<p>Continued From page 1</p> <p>houses where clients and visitors could view it. This failure resulted in clients and visitors being unable to directly report any allegations of abuse, neglect or misconduct.</p> <p>Findings include:</p> <p>1. Observation on 11/18/15 at 2:43 PM at 1040 House revealed the CRU telephone number could not be located in any of the common areas of the house.</p> <p>Interview on 11/18/15 at 3:16 PM with Staff B verified the CRU hotline phone number was not posted in any common area of the house for clients and visitors to view.</p> <p>Interview on 11/20/15 at 9:19 AM with Client #4's sister/guardian revealed she visits her brother every other week. Client #4's sister/guardian reported that she would report any concerns to Staff B but was unaware there was a CRU telephone number.</p> <p>2. Observation on 11/17/15 at 3:07 PM at 1030 House revealed the number for the State Complaint Resolution Unit (CRU) complaint telephone number was posted on the inside of the cabinet where Clients' files were kept on both the A and B sides of the house. The number was not posted in any other place at the house.</p> <p>Interview on 11/17/15 at approximately 3:15 PM with Staff C verified the telephone number for the CRU was not posted out in easily accessible locations.</p> <p>3. Observations on 11/17/15 at 9:10 AM of 1050 House revealed no postings which provided the</p>	W 125		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 125	Continued From page 2 CRU telephone number which informed Clients or Visitors how to report allegations of abuse, neglect or mistreatment to the CRU.  Interview at 9:30 AM on 11/17/15 with Staff CC verified no notice regarding contacting the CRU telephone number was posted.  4. Observations on 11/17/15 at 7:55 AM 2005 House revealed no postings which provided the CRU telephone number and informed Clients or Visitors on how to report allegations of abuse, neglect or mistreatment to the CRU.  Interviews at 8:10 AM on 11/17/15 with Staff AA and BB verified no notices regarding contacting the CRU telephone number were posted.	W 125			
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 reviews and interviews, the facility failed to ensure that all allegations of possible abuse, neglect and/or mistreatment were reported to the Complaint Resolution Unit (CRU). Failure to report allegations of abuse, neglect and mistreatment to the CRU prevents the State Agency from ensuring the facility is keeping clients safe.  Findings include:	W 153		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	Continued From page 3  Review of Facility Incident Reports (IR) #906241 and #902263 revealed an incident on 9/28/15 involving Client #11 was not reported to the Complaint Resolution Unit.  Record review on 11/18/15 and 11/19/15 of Client #11's file revealed a Health Interdisciplinary Progress Note dated 9/27/15 at 2:10 PM stated Client #11 used a butter knife and a fork to cut his [REDACTED]. An Interdisciplinary Progress Note dated 9/28/15 at 5:50 AM stated Client #11 used a broken bowl to cut himself. An Interdisciplinary Progress Note dated 9/28/15 at 8:00 AM and Facility Incident Reports #906241 and #902263, both dated 9/28/15 stated Client #11 obtained a steak knife and used it to cut himself.  Review of Client #11's Positive Behavior Support Plan (PBSP) dated 1/8/15 revealed Client #11 had a history of using objects to harm himself. Client #11's PBSP required all silverware and utensils to be kept in locked drawers and staff was directed to promptly collect and secure all silverware.  Interview on 11/18/15 at 11:15 AM with Staff V and on 11/19/15 at 10:30 AM with Staff U verified the facility had not reported Client #11 cutting his [REDACTED] on 09/27/15, cutting himself with a broken bowl on 9/28/15, and cutting himself with a steak knife as reported in IRs #906241 and #902263 to the CRU.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct a thorough investigation of possible incidents of abuse, neglect and/or mistreatment involving Client #11. Failure to do a thorough investigation prevented the facility from fully understanding what happened and to take appropriate client protection and corrective action.</p> <p>Findings include:</p> <p>Record review from 11/17/15 and 11/19/15 of Client #11's file revealed a Health Interdisciplinary Progress Note dated 9/27/15 at 2:10 PM stated Client #11 used a butter knife and a fork to cut his [REDACTED]. An Interdisciplinary Progress Note dated 9/28/15 at 5:50 AM revealed Client #11 used a broken bowl to cut himself. An Interdisciplinary Progress Note dated 9/28/15 at 8:00 AM and Facility Incident Reports #906241 and #902263, both dated 9/28/15, revealed Client #11 obtained a steak knife and used it to cut himself.</p> <p>Record Review of Client #11's Positive Behavior Support Plan (PBSP) dated 1/8/15 revealed Client #11 has a history of using objects to harm himself. Client #11's PBSP required all silverware and utensils to be kept in locked drawers and staff was directed to promptly collect and secure all silverware.</p> <p>The facility did an investigation of IRs #906241 and #902263. The investigation did not explain: a) The discrepancies between Staff X's statement of events and Staff Y's statement of events. b) Who was responsible for leaving the drawer with silverware unlocked with no staff present c) How,</p>	W 154		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 154	Continued From page 5 where and when the client obtained the steak knife. d) Why incidents discovered in progress notes from previous days not included in the investigation nor why corrective actions were not taken for those incidents.	W 154			
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS  The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure the results of an investigation of possible abuse, neglect and/or mistreatment were reported to facility administration within five working days of an incident involving Client #11 harming himself. Failure to report results of investigations into allegations of abuse, neglect and/or mistreatment to the facility administration prevented the facility administration from taking measures to ensure the client was safe.  Findings include:  Record review on 11/18/15 and 11/19/15 of Client #11's file revealed a Health Interdisciplinary Progress Note dated 9/27/15 at 2:10 PM which stated Client #11 used a butter knife and a fork to cut his [REDACTED]. An Interdisciplinary Progress Note dated 9/28/15 at 5:50 AM stated Client #11 used a broken bowl to cut himself. An Interdisciplinary Progress Note dated 9/28/15 at 8:00 AM and Facility Incident Reports #906241 and #902263, both dated 9/28/15 noted Client	W 156		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 156	Continued From page 6 #11 obtained a steak knife and used it to cut himself.  On 11/18/15 at 8:45 AM Staff U was asked for a copy of the facility's investigation report. The report had not been received by 9:30 AM and Staff V was asked to provide a copy of the report. He said he would provide it shortly. Staff V provided a copy of the investigation report at 11:20 AM.  Interview with Staff U revealed she completed the 5-Day Investigation Report regarding the 9/28/15 incident on 10/2/15. Interview with Staff V on 11/18/15 at 11:20 AM revealed he reviewed and signed the 5-Day Investigation Report regarding IRs #906241 and #902263 the morning of 11/18/15.	W 156			
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 record review and interview, the facility failed to take any corrective action following incidents in which 1 Expanded Sample Client (Client #11) harmed himself using silverware, a bowl and utensils which staff was to keep locked away so Client #11 could not harm himself. Failure of the facility to take appropriate corrective action following the incidents of self-harm placed Client #11 at risk for continued self-harm.  Findings include:	W 157		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 157	Continued From page 7 Record review on 11/18/15 and 11/19/15 revealed the Health Interdisciplinary Progress Note dated 9/27/15 at 2:10 PM stated Client #11 used a butter knife and a fork to cut his left arm. An Interdisciplinary Progress Note dated 9/28/15 at 5:50 AM revealed Client #11 used a broken bowl to cut himself. An Interdisciplinary Progress Note dated 9/28/15 at 8:00 AM and Facility Incident Reports #906241 and #902263, both dated 9/28/15, revealed Client #11 obtained a knife and used it to cut himself.  Interview with Staff V on 11/18/15 at 11:20 AM and with Staff U on 11/19/15 at 10:30 AM verified the facility had not taken corrective actions following the 9/27/15 incident of self-harm and the two 9/28/15 incidents of self-harm by Client #11.	W 157			
W 159	483.430(a) QIDP  Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure Qualified Intellectual Disability Professionals (QIDP) were managing all aspects of the Clients' active treatment process for 6 of 10 Sample Clients (Clients # 1, #2, #3, #7, #8, and #9) and 2 of 3 Expanded Sample Clients (Clients #12 and #13). This failure prevented Clients from receiving Active Treatment Services which would ensure progress toward becoming more independent and placement in a less restrictive setting.  Findings include:  1. The facility failed to ensure 2 of 10 Sample	W 159		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 8</p> <p>Clients (Clients #3 and #9) and 2 of 3 Expanded Sample Clients (Clients #12 and #13) received an aggressive program of services designed to meet their assessed needs. This failure prevented these Clients from having the opportunity to learn skills, to increase their independence, and move to a less restrictive living setting. (See W196 for details)</p> <p>2. The facility failed to ensure the behavioral management needs of 1 of 10 Sample Clients (Client #8) were identified and supports put in place to ensure her safety. This failure resulted in the Client eloping from supervision and putting herself at risk for injury. (See W214 for details)</p> <p>3. The facility failed to ensure 1 of 10 Sample Clients (Client #8) and 1 of 3 Expanded Sample Clients #12 had objectives that were written in singular fashion, with only one discrete behavior being trained and monitored. Failure of the facility to ensure that objectives were written in singular format prevented staff from determining which specific skill the Client was learning, maintaining or showing regression. (See W229 for details)</p> <p>4. The facility failed to promote choice and self-management of 2 of 10 Sample Clients (#8 and #9) when staff prepared, served and cleaned before/after meals and snacks. This failure prevented Clients from learning valuable skills that promote independence and choice. (See W247 for details)</p> <p>5. The facility failed to ensure 2 of 10 Sample Clients (Clients #1 and #8) had Individual Program Plans (IPP) that were implemented as they were written. This failure prevented Clients</p>	W 159			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 9</p> <p>from receiving training for their current needs and prevented them from having the opportunity to become more independent. (See W249 for details)</p> <p>6. The facility failed to provide Active Treatment Schedules for 1 of 10 Sample Clients (Client #9) and 1 of 3 Expanded Sample Clients (Client #13) that directed staff on how and when to implement activities designed to teach independence over the course of the Client's day. This failure prevented the Clients from having staff who knew when and what to be doing with them throughout the day. (See W250 for details)</p> <p>7. The facility failed to ensure 3 of 10 Sample Clients (Client #2, #7 and #8) and 1 of 3 Expanded Sample Clients (Client #12) had objectives with data in a form that would allow progress to be determined. This failure prevented the facility from being able to know how the Clients were progressing on their training objectives. (See W252 for details)</p> <p>8. The facility failed to ensure that completed objectives for 2 of 10 Sample Clients (Client #7 and #9) were identified, modified or changed to meet the needs or accomplishments of the Client. This failure prevented Clients from having new needs identified and from obtaining new training skills. (See W255 for details)</p> <p>9. The facility failed to ensure 1 of 10 Sample Clients (Client #3) had their IHP redone in response to a significant mental health crisis which significantly changed his behavior. Failure to redo the IHP in response to a significant change prevented the facility from aggressively meeting his current needs. (See W256 for</p>	W 159			

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>11/20/2015</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)	D 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 10 details)	W 159			
W 195	<p>10. The facility failed to update 1 of 10 Sample Clients ' (Client #3) Comprehensive Functional Assessment (CFA) when he experienced a significant change in functioning due to a mental health crisis. Failure to update and change the CFA prevented the facility from having a clear picture of the Client ' s current strengths and weaknesses so that an IHP, which meets the current needs, was developed. (See W259 for details)</p> <p>483.440 ACTIVE TREATMENT SERVICES</p> <p>The facility must ensure that specific active treatment services requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to develop and implement systems that resulted in Clients receiving ongoing assessments, training programs to meet their needs, consistently implemented plans, and regular oversight and updating of the plan. This failure resulted in Clients ' needs not being addressed, failure to progress on plans without changes, and spending significant periods of time not engaged in activities designed to increase their independence.</p> <p>Findings include:</p> <p>1. The facility failed to ensure 2 of 10 Sample Clients (Clients #3 and #9) and 2 of 3 Expanded Sample Clients (Clients #12 and #13) received an</p>	W 195		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 195	<p>Continued From page 11</p> <p>aggressive program of services designed to meet their assessed needs. This failure prevented these Clients from having the opportunity to learn skills, to increase their independence, and move to a less restrictive living setting. (See W196 for details)</p> <p>2. The facility failed to ensure the behavioral management needs of Client #8 were identified and supports put in place to ensure her safety. This failure resulted in the Client eloping from supervision and putting herself at risk for injury. (See W214 for details)</p> <p>3. The facility failed to ensure 1 of 10 Sample Clients (Client #8) and 1 of 3 Expanded Sample Clients #12 had objectives that were written in singular fashion, with only one discrete behavior being trained and monitored. Failure of the facility to ensure that objectives were written in singular format prevented staff from determining which specific skill the Client was learning, maintaining or showing regression. (See W229 for details)</p> <p>4. The facility failed to promote choice and self-management of 2 of 10 Sample Clients (#8 and #9) when staff prepared, served and cleaned before/after meals and snacks. This failure prevented Clients from learning valuable skills that promote independence and choice. (See W247 for details)</p> <p>5. The facility failed to ensure 2 of 10 Sample Clients (Clients #1 and #8) had Individual Program Plans (IPP) that were implemented as they were written. This failure prevented Clients from receiving training for their current needs and prevented them from having the opportunity to</p>	W 195			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 195	<p>Continued From page 12 become more independent. (See W249 for details)</p> <p>6. The facility failed to provide Active Treatment Schedules for 1 of 10 Sample Clients (Client #9) and 1 of 3 Expanded Sample Clients (Client #13) that directed staff on how and when to implement activities designed to teach independence over the course of the Client's day. This failure prevented the Clients from having staff who know when and what to be doing with Clients throughout the day. (See W250 for details)</p> <p>7. The facility failed to ensure 3 of 10 Sample Clients (Client #2, #7 and #8) and 1 of 3 Expanded Sample Clients (Client #12) had objectives with data in a form that would allow progress to be determined. This failure prevented the facility from being able to know how the Clients were progressing on their training objectives. (See W252 for details)</p> <p>8. The facility failed to ensure that completed objectives for 2 of 10 Sample Clients (Client #7 and #9) were identified, modified or changed to meet the needs or accomplishments of the Client. This failure prevented Clients from having new needs identified and from obtaining new training skills. (See W255 for details)</p> <p>9. The facility failed to ensure 1 of 10 Sample Clients (Client #3) had their IHP redone in response to a significant mental health crisis which significantly changed his behavior. Failure to redo the IHP in response to a significant change prevented the facility from aggressively meeting his current needs. (See W256 for details)</p>	W 195			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 195	Continued From page 13 10. The facility failed to update 1 of 10 Sample Client's (Client #3) Comprehensive Functional Assessment (CFA) when he experienced a significant change in functioning due to a mental health crisis. Failure to update and change the CFA prevented the facility from having a clear picture of the Client's current strengths and weaknesses so that an IHP, which meets the current needs, was developed. (See W259 for details)	W 195			
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 specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.  This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 10 Sample Clients (Clients #3 and #9) and 2 Expanded Sample Clients (Clients #12 and #13) received an aggressive program of services designed to meet their assessed needs. This failure prevented these Clients from having the opportunity to learn skills to increase their independence and move to a less restrictive living setting.  Findings include:	W 196		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 14  Client #3:  1. Observation on 11/16/15 at 2:30 PM to 2:49 PM at 1030 House revealed Client #3 was lying on his bed with music playing. At 2:42 PM a staff partially closed his bedroom door. At 2:49 PM a staff asked him if he wanted to join them for games. Client #3 refused. During this time Client #3 was not engaged in any training activities.  2. Observation on 11/17/15 from 6:55 AM to 8:31 AM at 1030 House revealed Client #3's bedroom door was closed. At 7:25 AM Client #3 went into the bathroom and used the toilet. (The door to the bathroom was open.) He then went back into his bedroom and closed the door. At 7:27 AM a staff went into his room for a brief moment and then came back out. At 8:12 AM the bedroom door was still closed, but a staff opened the door briefly and then closed it again. At 8:22 AM Client #3 came out and went into the bathroom, and used the toilet. (The door to the bathroom was open.) A staff said good morning to him and he responded "Oh, shut up" and slammed the bedroom door shut. At 8:29 AM a staff entered the room briefly and then left. During this time Client #3 was not engaged in any training activities.  3. Observation on 11/17/15 from 10:42 AM to 11:07 AM at 1030 House revealed Client #3 was lying on his bed in his bedroom with the lights out. Music was playing in the bedroom. During this time Client #3 was not engaged in any training activities.  4. Observation on 11/18/15 from 8:27 AM to 10:36 AM at 1030 House revealed Client #3 was	W 196			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	<p>Continued From page 15</p> <p>in his bedroom with his coat on. He was asked by staff if he wanted to go on a "van ride". He did not go on the ride, but came out of his bedroom and wandered around in the front common area of Side B of 1030 House. He then sat down in a chair, periodically putting his fingers in his ears and looking at the clock. At 8:49 AM a staff asked him if he wanted to help him with some paperwork, but he did not help. At 8:58 AM a staff asked him if he wanted money to go to the Coffee Shop, and he stood up and followed staff to get the money. At 9:03 AM he was told he could go to the Coffee Shop. He left by himself and returned to the house at 9:15 AM with a grocery bag. He went into his bedroom and drank a pop. He took the can to the recycling bin and then returned to his room and drank a second pop. He also recycled that can. He then sat down in a common area on B side of the house. At 10:20 AM he was asked to help with laundry but adamantly refused. At 10:28 AM he walked back to the hallway where his bedroom was and stood or sat on a bench out in the hallway until 10:36 AM when the observation ended. During this time Client #3 was not engaged in any training activities.</p> <p>5. Observation on 11/18/15 from 2:00 PM to 3:40 PM at 1030 House revealed Client #3 was sitting in a chair on the B side of the house with his coat on. At 2:12 PM he was asked if he wanted a snack, and he went into the kitchen and got a pop which he drank in his bedroom. At 2:25 PM he was observed sitting in the TV room of the B side of 1030 House. At 2:40 PM a staff asked him how he was doing. At 2:43 PM a staff talked to him for a couple of minutes, but then the staff left and Client #3 continued to sit. At 2:53 PM a staff</p>	W 196		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 16</p> <p>asked him if he wanted to go to cooking class, but he said "no". The observation ended at 3:40 PM and Client #3 was not engaged in any training activities.</p> <p>Interview on 11/18/15 at 9:40 AM at 1030 House with Staff C revealed Client #3 had a significant mental health decompensation episode earlier in the year. Since then staff have not pushed him because of his verbal outbursts and yelling.</p> <p>Record review on 11/19/15 at 1:30 PM of Client #3's file revealed he had suffered a significant change in his functioning in [REDACTED] 2015. These changes resulted in a stay in the hospital and he returned to the facility in [REDACTED] 2015. Client #3's Comprehensive Functional Assessment (CFA) and Individual Habilitation Plan (IHP) were not redone as a result of this significant change in functioning.</p> <p>Interview on 11/19/15 at 3:30 PM with Staff D verified the facility had not redone the CFA or IHP as a result of this significant change in functioning. He verified the facility had dealt with the changes through Ad-Hocs (meetings with subsequent written changes) to the IHP that was in place prior to the change in functioning. He verified the changes primarily suspended programs that were in place, but did not detail out a changed plan based on Client #3's current needs.</p> <p>Client #9</p> <p>1. Observation on 11/17/15 from 8:20 AM to 9:30 AM at 1010 House revealed Client #9 wandering the service hallway on 1010 House with his 1:1 staff, standing within arm's reach of him. Client #9</p>	W 196			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 17 tried to open several hallway doors however they were all locked. Client #9 then wandered into the dining room trying to collect his dining dishes but he was redirected away from the kitchen. Client #9 then roamed the back hallways of the house and ended up back in the kitchen. Client #9 stood in the kitchen flexing his hands and then clutching them into fists. Staff redirected him to take out the trash, however he was not interested in doing so. Client #9 was handed the trash bag and cued to follow his 1:1 staff outside to put it in the large dumpster however it was raining and Client #9 refused to go outside. At 8:35 AM, Client #9 was directed by his 1:1 staff to go into his bedroom to change his clothing. At 8:45 AM, Client #9 exited his bedroom with fresh clothes on. He went directly into the kitchen where he was cued to put trash bags inside the cans in the house. Client #9 refused, exited the kitchen and began to roam the back hallways of the house again, his 1:1 staff following him. At 8:55 AM Client #9 was cued to sit down at a table and assemble wooden puzzles. He sat for only a minute and began to wander the halls of the house again, attempting to open locked doors in the service hallway. At 9:00 AM Client #9 was cued to get his coat on to go for a walk with his 1:1 staff. Staff assisted Client #9 to put his coat on however he refused to leave the house. At 9:05 AM staff cued Client #9 to push a cart of clean dishes from the kitchen to the dining room, which he did stating "Eat. Eat." Staff reminded Client #9 he had just finished breakfast and would have to wait until 10:00 AM to eat again. Staff then went into the kitchen and got Client #9 a glass of water, put thickener in it, stirred it and gave it to Client #9 to drink. Client #9 was cued to sit down at the dining room table (with his coat still on) to drink his water. He drank the water and staff left to get him another glass of	W 196			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 18</p> <p>water. Client #9 drank both glasses of water quickly and began to wander the halls of the house again. At 9:15 AM staff cued Client #9 to put table clothes on each table in the dining room. Client #9 did not want to do the task and he began to wander the house again. At this time, Client #9 was the only client on the house, wandering the halls with his coat on and his 1:1 staff following him. Staff L retrieved the petty cash box from a secured room in the service hallway and brought it to a table where he prepared to give \$1.00 to Client #9 for a trip to the coffee shop. Client #9 signed a sheet of paper and was given his \$1.00 to hold however he continued to roam the house until 9:30 AM when he and his 1:1 staff left the house to go to the coffee shop. Other than holding a trash bag and pushing a cart of clean dishes into the dining room, Client #9 did not engage in any meaningful training activities.</p> <p>2. Observation on 11/17/15 from 1:10 PM to 1:45 PM at 1010 House revealed Client #9 was standing in the service hallway of 1010 House rocking back and forth on his feet attempting to open secured doors in the service hallway. His 1:1 staff was standing nearby. At 1:15 AM Client #9's 1:1 staff unlocked the laundry room door and cued Client #9 to transfer laundry from the washer to the dryer. Client #9 did so independently. He then exited the laundry room and went to the kitchen where he got his adaptive dining dish. He then sat at a nearby table. Client #9 sat for 1 minute before getting up to roam the hall again. At 1:25 PM Client #9 was cued to get juice in the kitchen. He exited the kitchen with a water bottle full of thickened juice. His 1:1 staff poured small amounts of juice into a glass for Client #9. He drank the juice quickly, emptying</p>	W 196			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 19</p> <p>the contents of the water bottle. He then dumped the bottle and glass in the kitchen sink. At 1:30 PM, Client #9 grabbed his adaptive dining dish from the kitchen counter, however he was cued to put it back by staff and told he would have to wait to eat. Client #9 made several attempts to get his dining dish but he was redirected. He became angry and threw a fabric bag on the floor and stomped into the dining room. At 1:36 PM, Client #9 paced in the dining room and staff positioned themselves between him and the kitchen door while Client #9 rocked back and forth on his feet, attempting to get into the kitchen. The Surveyor left the house at 1:45 PM, noting Client #9 still attempting to get into the kitchen. Other than placing his dishes in the kitchen sink and transferring laundry from the washer to the dryer, Client #9 did not engage in any other meaningful activity.</p> <p>3. Observation on 11/18/15 from 8:30 AM to 8:45 AM revealed Client #9 standing near the kitchen. Staff cued Client #9 to get his coat to go to the coffee shop. Client #9 refused to leave the house. He then wandered about the halls, kitchen and dining room until his 1:1 staff managed to persuade him to go to the coffee shop. They left the house at 8:45AM.</p> <p>Record review on 11/19/15 at 10:30 AM of Client #9's IHP dated 3/12/15 revealed formal training programs to reduce self-abuse, physical aggression and other socially inappropriate behaviors and formal training objectives to address a variety of activities of daily living (showering, tooth brushing and dressing). The IHP also notes opportunities for vocational training, swimming, off campus trips, etc. Review of the file revealed an active treatment schedule</p>	W 196			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 196	<p>Continued From page 20</p> <p>that was generic and included long periods of unstructured time or little activity e.g.: 8:00 AM - 11:00 AM prepare for work or day (work/leisure), 13:00 PM - 16:30 PM Leisure/Rec/Social.</p> <p>Interview on 11/19/15 at 3:50 PM with Staff P and Staff Q revealed Client #9 spends large amounts of time doing nothing and that he needs consistent structure to engage in activities in order to gain independence. Staff P admitted that 1:1 support staff need better training on how to best engage the Clients they are working with. Staff P indicated that Client #9 should be consistently cued to serve himself his meals, encouraged to go off the house more and admitted that some activities (van rides) are more busy activities versus structured activities to increase client's chances to move to a less restrictive setting.</p> <p>Client #12</p> <p>1. Observation on 11/17/2015 from 7:29 AM to 11:04 AM at [REDACTED] revealed Client #12 was in his room with the door closed. Client #12 remained in his room with the door closed until 7:45 AM. At 7:45 AM Client #12 was taken to the nurse to get his medications. Client #12 stiffened and started shaking when he got close to the nurse station. Client #12 was assisted into a chair. Staff said "I think he's having a seizure". At 7:47 AM Client #12 regained his focus. Staff E asked client #12 if he wanted to "take his medication?", but he refused and went into the bathroom. At 7:50 AM Client #12 exited the bathroom and went back into bedroom and closed the door. At 7:55 AM Staff E asked surveyors if they "would move into another part of the house because Client #12 liked to isolate</p>	W 196		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 21</p> <p>himself and gets anxious in front of strangers". At 8:05 AM Staff E attempted to get Client #12 to take his medication again. Client #12 refused and remained in his room with the door closed. At 8:11 AM Client #12 was asked again if he wanted to take his medication by Staff E. Client #12 refused and remained in his room with the door closed. At 8:12 AM Staff F asked Client #12 "how are you doing?" Client #12 remained in room with the door closed after contact. At 8:14 AM the nurse knocked and then entered the client's room. She asked Client #12 how he was doing. Client #12 gave an answer then the nurse exited the room and closed the door. At 8:21 AM Staff E knocked on Client #12's door, entered the room, and then shut the door behind her. At 8:24 AM Staff E exited the room and closed the door. At 8:31 AM Client #12 was still in his room with the door closed. Sometime after 8:35 AM Client #12 went on a van ride to Mud Mountain Dam. At 10:42 AM Staff F stated Client #12 is out on a van ride/community trip. At 11:03 AM the Surveyor heard staff state that the Clients went to Mud Mountain Dam recreation area on the trip. Staff stated "Location was kind of flooded, but it had bathrooms and a parking area". The Surveyor noted the weather was very stormy that day with lots of wind and rain. At 11:04 AM Client #12 was in his room with the door closed. The Surveyor knocked and saw Client #12 looking out his window. Client #12 was not engaged in any training activities geared towards independence.</p> <p>2. Observation on 11/18/15 from 8:27 AM to 11:00 AM at [REDACTED] and a trip into the community revealed Client #12 was awake and in his bedroom with the door open. Staff F came by and asked if he wanted his door shut. Client #12 requested that the door stay open. At 8:28 AM</p>	W 196			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 22 Client #12 exited his bedroom and entered the bathroom. At 8:29 AM Client #12 exited the bathroom and began to shut his door when Staff F asked if he wanted to go on a van ride. He said no. Staff F told the client they would ask him again later. Client #12 entered his room and shut the door. At 8:43 AM Client #12 was in his room with the door closed. At 8:43 AM Staff F explained that Client #12 had been going through changes recently. He had a new trainer at work and hadn't attended since August, 2015. At 8:46 AM Staff C entered Client #12's room with his roommate. Staff C told Client #12 to get his jacket on. Client #12 remained in his room with the door shut. At 8:54 AM Client #12 remained in his room with the door shut. At 8:57 AM Staff F entered the room and informed Client #12 the van ride will leave soon and staff will come and get him. Client #12 remained in his room with door closed. At 9:03 AM Staff F entered Client #12's room and asked him if he wanted to go on van trip. Client #12 said no. At 9:04 AM Staff G entered Client #12's room. He encouraged him to go on the van ride. Client #12 then followed Staff G to van. At 9:08 AM Client #12 was sitting in the van, wearing a seat belt. At 9:10 AM Surveyor asked Staff C where the van ride was going? He stated he didn't know but would find out. Staff C came back a minute later and told the Surveyor the van was going to a BMX Park. At 9:14 AM the van left the facility with two Staff and 2 other Clients. At 9:54 AM the van arrived at Riverside County Park in Sumner, WA. While at the park, two out of the three clients exited the van. Those clients used the portapotty and then went right back into the van. Client #12 did not get out of the van. At 10:14 AM the van departed the recreation area. At 10:54 AM the van arrived back at the facility. At 11:00 AM Client #12 was back in his room. The	W 196			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 23 surveyor knocked on his door and opened it to see Client #12 looking out his window. Client #12 was not engaged in any training activities geared towards independence.  3. Interview on 11/18/15 at 1:52 PM with Staff F revealed Client #12 was on another van ride and he would be back at 2:00 PM. Staff F was unaware of where the van went. At 2:06 PM Client #12 came back from the van ride, entered his room, and shut the door. At 2:20 PM Client #12 was still in his room with the door shut. At 2:24 PM Staff I knocked and entered Client #12's room and asked him why he didn't go to work today. Staff I exited the room a short time later leaving Client #12 in his room with the door closed. At 2:27 PM Staff H met with Client #12 and asked him how he was doing. Staff H stated "you kept people safe on the van ride" . Staff H chuckled and then left the room and closed the door. At 2:35 PM Client #12's roommate came back and threw his jacket in the room. Client #12 picked up the jacket and hung it up and then closed the door. At 2:41 PM Client #12 exited the bedroom. Staff H asked Client #12 if he wanted to play Yahtzee. Client #12 said no then went into his room and closed his door. At 2:53 PM Client #12 was asked by Staff H if he would like to attend cooking class. Client #12 said no. Staff H mentioned that they would be making pizza and it would be fun. Client #12 still refused and went into his room and closed the door. At 3:03 PM Staff H attempted to ask Client #12 again if he wanted to go to cooking class, but the bedroom door was locked. Staff H didn't try to enter. At 3:05 PM Staff H came back to Client #12's room again, unlocked the door and asked Client #12 about going to the cooking class again. Client #12 refused and Staff H closed the bedroom door and	W 196			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	<p>Continued From page 24</p> <p>left. At 3:16 PM Staff H once again asked Client #12 if he wanted to go to cooking class. Client #12 refused again. At 3:19 PM Client #12 was in his room with the door closed. Client #12 was not engaged in any training activities geared towards independence.</p> <p>Record review on 11/19/15 revealed that Client #12 had steadily attended work up until March of 2015 and was performing well. In April his attendance started to trend downwards. He has not attended work since early July and there was no indication this behavior was being addressed. The IHP didn't address Client #12's isolation behavior.</p> <p>Interview on 11/20/15 verified Staff D was aware that Client #12 had not attended work since July, 2015. Staff D also verified Client #12 went 8 months without any activities planned to get Client #12 to participate in vocational training.</p> <p>Client #13</p> <p>1. Observation on 11/18/15 from 8:48 AM to 9:30 AM at 1040 House revealed Client #13 was observed sitting in his wheelchair in the dining room area near a window on the B side of 1040 House playing with his sock. No staff tried to engage him in any training activity.</p> <p>2. Observation on 11/18/15 from 2:47 PM to 3:39 PM at 1040 House revealed Client #13 was in his bedroom with the door closed. At 3:10 PM the surveyor entered the bedroom and observed Client #13 sleeping in his bed. No staff tried to</p>	W 196			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 25 engage Client #13 in any training activity.  3. Observation on 11/19/15 from 9:15 AM to 9:34 AM at 1040 House revealed Client #13 sitting in his wheelchair in the living room on the A side of the house playing with his sock. No staff tried to engage Client #13 in any training activity.  Record review on 11/19/15 at 1:30 PM of Client #13's IHP dated 2/24/2015 revealed the active treatment focus was "He will continue to be offered opportunities to participate in the activities that will compete with his self-stimulating behavior of shredding socks and manipulating his shoelaces."  Interview on 11/19/15 at 3:32 AM with Staff A and Staff B revealed Client #13 was difficult to engage in activities and refused most of the time. Staff B reported Client #13 will not engage in activities with newer staff and seeks out staff that have been around longer.  Interview on 11/20/15 at 9:10 AM with Staff O revealed Client #13's plan had remained the same for years and he was mostly receiving custodial care at this point.	W 196			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.  This STANDARD is not met as evidenced by: Based on observation, record review and	W 214		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	<p>Continued From page 26</p> <p>interview, the facility failed to ensure the behavioral management needs of Client #8 were identified and supports put in place to ensure her safety. This failure resulted in the Client eloping from supervision and putting herself at risk for injury.</p> <p>Findings include:</p> <p>Client #8</p> <p>1. Observation on 11/19/15 from 9:25 AM to 10:04 AM of Client #8 while at her work station at Oakley House, revealed she attempted to leave the work area 12 different times and staff had to direct her back to her work station each time.</p> <p>Record review on 11/18/15 at 9:20 AM of Client #8's file revealed progress notes from 8/04/15 to 10/18/15 indicated elopements and attempted elopements off of her home on 44 separate occasions.</p> <p>Record review on 10/18/19 at 9:30 AM of Client #8's Individual Habilitation Plan (IHP) dated 12/18/14 and Behavior Support Plan (BSP) with an expiration date of 4/11/16 revealed the IHP and BSP did not identify or track elopement.</p> <p>Interview on 11/18/15 at 9:30 AM with Staff J revealed that she was aware that Client #8 gets in moods and elopes off of the house. She was aware the BSP did not address elopement but she informed the Surveyor that house staff alert each other on days when Client #8 appears to be restless so they can keep an eye on her to keep her safe.</p> <p>Interview on 11/19/15 at 10:04 AM with Staff K</p>	W 214			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 214	Continued From page 27 verified that when Client #8 eloped from her work area, staff had to go get her to keep her from getting lost or hurt. Staff K reported that when she followed Client #8, she was leaving the other five peers alone in the room and unsupervised until she was able to return with Client #8.	W 214			
W 229	Interview on 11/19/15 at 4:15 PM with Staff L, Staff M and Staff N verified that elopement was not identified as a need in IHP or BSP. 483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN  The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.  This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 10 Sample Clients (Client #8) and 1 of 3 Expanded Sample Clients (Client #12) had objectives that were written in singular fashion, with only one discrete behavior being trained and monitored. Failure of the facility to ensure that objectives were written in singular format prevented staff from determining which specific skill the client was learning, maintaining or showing regression.  Findings include:  Client #8  Record review on 11/19/15 at 10:30 AM of Client #8's Individual Habilitation Plan (IHP) dated 12/18/14 revealed an objective #1097, which had a program revision dated 9/22/15, stated: "Given	W 229		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 229	<p>Continued From page 28</p> <p>initial cue, [Client #8's first name] will pick up her tooth brush and hand it to staff (staff to brush her teeth) with 50% or greater accuracy for 4 of 5 consecutive months, by 1/16". The objective is not singular as it requires two skills: 1. pick up the tooth brush, and 2. Hand the tooth brush to staff.</p> <p>Record review on 11/19/15 at 9:50 AM of Client #8's vocational file at Oakley House revealed Client #8's IHP dated 12/18/14 with a vocational objective #5142: [Client #8's first name] will complete each of 4 steps to twist wire with an average score of 3 or higher for 6 consecutive months. The objective is not singular; it requires 4 separate skills to complete the task.</p> <p>Interview on 11/19/15 at 3:50 PM with Staff L and Staff M verified objectives #1097 and #5142 were not written in singular terms as required.</p> <p>Client #12</p> <p>Record review on 11/19/2015 of Client #12's IHP dated 12/04/14 revealed objective #5146 stated "[Client #12's name] will complete each of four steps to put tag on clothing using needle gun with an average of 3.8 for 3 consecutive months". Review of the program revealed 4 different skills; stage clothing item to be tagged, place tag on designated area of the piece of clothing, pierce needle of gun through hole in tag and 1 layer of garment, and pull trigger of gun to affix tag. The objective is not singular; it requires 4 separate skills to complete the task.</p> <p>Interview on 11/19/2015 at 3:30 PM with Staff D about objective #5146 for Client #12 revealed the objective had been written by the vocational training staff and Staff D had just placed it in the</p>	W 229			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 229	Continued From page 29 IHP as is. Staff D acknowledged there were 4 skills to the defined behavior instead of one singular skill.	W 229			
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, record reviews and interviews, the facility failed to promote choice and self-management for 2 of 10 Sample Clients (#8 and #9) when staff prepared, served and cleaned before/after meals and snacks. This failure prevented Clients from learning valuable skills that promote independence and choice.  Findings include:  Client #8:  1. Observation on 11/16/15 at 2:25 PM at 1020 House revealed Client #8 being led hand in hand by house Staff to the dining room where Staff had placed a tray of coffee cups, spoons, a pitcher of hot water, sugar and cream packets, coffee and hot cocoa packets on the dining room table. Client #8 was cued to sit at the table. Client #8 grabbed the pitcher full of hot water and began to drink out of it. Staff redirected Client #8 to put the pitcher down, removed the pitcher from the dining room, got a new pitcher of hot water and gave Client #8 a coffee mug full of hot coffee to drink. Client #8 drank the coffee quickly and immediately left the table to go lie down on a couch on the other side of the house. Client #8 was not given the choice on what she would like to drink nor was she cued to help prepare her	W 247		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	<p>Continued From page 30 drink or assist with the clean-up.</p> <p>2. Observation on 11/17/15 at 7:15 AM at 1020 House revealed Client #8 being led hand in hand by Staff to the dining room where she was cued to sit. Staff then put a protective covering around Client #8's neck, put cereal and milk in a bowl for her and handed her a long handled spoon in her left hand, along with a cut away glass. Client #8 ate her cereal and drank her juice independently. At 7:25 AM Staff approached the table, told Client #8 she was done eating, and Staff took her dishes into the kitchen. Client #8 was then led, hand in hand by staff, to the other side of the house to use the bathroom. Client #8 was not given the choice on what she would like to eat, nor was she cued to dish up her meal or assist in the clean-up.</p> <p>3. Observation on 11/17/15 at 10:35 AM at 1020 House revealed Client #8 being handed a small glass of apple juice and a bowl of Sun Chips. After Client #8 finished her snack, Staff took the dishes into the kitchen. Client #8 did not have the opportunity to choose, make nor assist with the clean-up of her snack.</p> <p>4. Observation on 11/17/15 at 11:00 AM at 1020 House revealed staff preparing lunch in the kitchen while Client #8 wandered the back halls of the house. At 11:15 AM, Client #8 was taken into the dining room and cued to sit at the table. Client #8 had no food on her plate however she watched two peers seated at her table eat their meal. The two peers finished their meal and independently took their dishes to the kitchen. At 11:25 AM, Staff offered Client #8 a sandwich, cut it up for her and placed a protective covering around her neck. At 11:30 AM Client #8 left the</p>	W 247			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	<p>Continued From page 31</p> <p>dining room table and proceeded to wander the back hallways with her protective covering still around her neck. Client #8 was not offered an a choice of what to eat, did not assist in the preparation of the meal, nor the set-up or clean-up of the meal.</p> <p>5. Observation on 11/18/15 at 1:25 PM at 1020 House revealed Client #8 was led by staff to the dining room table for coffee break. She was cued to sit at the dining table with four peers. Staff had placed a tray with items for coffee/cocoa on it (cream/sugar, mugs, spoons, hot water pitcher). Staff poured water into cups. Client #8 was handed a regular coffee mug with coffee in it. She drank it and then left the table. Client #8 did not get to choose what she wanted to drink nor was she cued to assist in the preparation or clean-up of the snack.</p> <p>6. Observation on 11/18/15 at 4:05 PM at 1020 House revealed Client #8 wandering around the house with her coat on. Staff verbally cued her to take off her coat but she continued to wander the hallway. At 4:25 PM a house Staff approached Client #8 and took her coat off of her and placed it in her bedroom. Client #8 was not asked again to remove her coat nor was she cued to put it in her bedroom.</p> <p>7. Observation on 11/19/15 at 8:45 AM at 1020 House revealed Staff cued Client #8 to put her coat on. Client #8 did not respond to the cue. Staff went into Client #8's bedroom, found her coat, and put it on her without cueing her to assist putting her coat on. Client #8 arrived at her vocational site at 8:55 AM. Staff K removed her coat for her and placed it on the back of an office chair. Client #8 was not cued to remove her own</p>	W 247			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	<p>Continued From page 32 coat.</p> <p>8. Observation on 11/19/15 at 9:55 AM at 1020 House revealed Staff K cued a peer to get Client #8 a glass of juice. The Peer took Staff K's keys and brought a paper cup of apple juice to Client #8. Client #8 had difficulty drinking from the paper cup, squeezing it and nearly spilling the contents. Staff K held the paper cup for Client #8 to drink from to avoid spilling the juice. Client #8 was not cued to choose nor prepare a drink for herself.</p> <p>Record review on 11/19/15 at 10:30 AM revealed Client #8's Individual Habilitation Plan (IHP) dated 12/18/14 (and IHP revision dated 9/22/15) had a formal objective #1024 which stated "Given full physical assistance, [Client #8's first name] will bus dishes (or utensils) to the kitchen following a meal or snack with 60% or greater accuracy for 4 of 5 consecutive months, by 1/16".</p> <p>Record review on 11/19/15 at 10:30 AM of Client #8's Comprehensive Functional Assessment (CFA) dated 12/4/14 revealed on page 3 under B. Safety #3: "She is encouraged to bus her dishes after meals and assist with putting on, taking off and disposing of the briefs".</p> <p>Interview on 11/19/15 at 4:15 PM with Staff M, Staff L, and Staff N verified staff should encourage Client #8 to serve her own food, bus her own dishes to the kitchen and she should be encouraged to do more for herself during dressing.</p> <p>Client #9:</p> <p>1. Observation on 11/16/15 at 11:20 AM at 1010</p>	W 247			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	<p>Continued From page 33</p> <p>House revealed Client #9 was cued by his 1:1 Staff to get his dining equipment (high sided plate) which he did. He was then cued to sit at the dining room table while his 1:1 Staff dished his meal into a separate bowl and cut it into small bite size pieces for him per the dining protocol. Another staff then gave Client #9 his adaptive utensil and a glass. Client #9 did not have the opportunity to choose what he wanted to eat nor did he have the opportunity to serve himself.</p> <p>2. Observation on 11/16/15 at 11:45 AM at 1010 House revealed a staff collected the leftover food containers, took them to the kitchen, rinsed the dishes and cleaned up the kitchen counters. Other than being cued to bus his high sided dish to the kitchen sink, Client #9 was not cued to assist in the meal clean up.</p> <p>3. Observation on 11/17/15 at 9:05 AM at 1010 House revealed Client #9 sitting at the dining room table. His 1:1 staff went into the kitchen, got a glass of water, put thickener in it and handed the glass to Client #9. Client #9 drank the glass of water quickly so staff got him another glass of water, added thickener to it and handed it to him. Client #8 did not have the opportunity to choose his drink, prepare his drink (add thickener), nor assist in getting it.</p> <p>4. Observation on 11/18/15 at 4:40 PM at 1010 House revealed Client #9 was seated at the dining room table. Staff dished up Client #9's meal for him. Client #9 was not given the opportunity to choose what he wanted to eat nor allowed to serve himself.</p> <p>Record review on 11/19/15 at 11:00 AM of Client #9's IHP dated 3/12/15 noted a Service Care Plan</p>	W 247			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 247	Continued From page 34 #1017 that revealed staff are to assist Client #9 to make healthy beverage choices and to provide alternate choices of pop, tea, cocoa, juices, water and milk.  Record review on 11/19/15 at 11:15 AM of Client #9's CFA dated 3/12/15 revealed on page 6, #3: He busses his own dishes and has the ability to wash his own dishes as well.  Interview on 11/19/15 at 3:50 PM with Staff P, Staff Q and Staff verified Client #9 is capable of serving himself his meals and staff should have involved him in choosing what he wants to eat and drink and serving himself meals.	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 record review and interview, the facility failed to ensure that 2 of 10 Sample Clients (Clients #1 and #8) had Individual Program Plans (IPP) that were implemented as they were written. This failure prevented the Clients from receiving training for their current needs and prevented them from having the opportunity to become more independent.	W 249		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 35</p> <p>Findings include:</p> <p>Client #1</p> <p>Record review on 11/19/15 at 9:20 AM revealed Client #1's Individual Habilitation Plan (IHP) dated 3/12/15 had Objective #5047 "[Client #1's Name] will sort incoming items by taking them to the proper sorting bin 5-15 ft. away with an average of 4.0 for 6 consecutive months."</p> <p>Interview on 11/19/15 at 8:30 AM revealed Client #1 was retired and was not doing any sorting. He had been offered other jobs at the facility but he did not want to work.</p> <p>Interview on 11/19/15 at 10:30 AM with Staff A verified Client #1 was not working towards meeting Objective #5047 and it was discontinued on 7/28/15.</p> <p>Interview on 11/19/15 at 3:00 PM with Staff A verified he had not replaced Client #1's Objective #5047 although Client #1 had not progressed towards the objective for several months.</p> <p>Client #8:</p> <p>1. Observation on 11/16/15 at 2:25 PM at 1020 House revealed Client #8 being led hand in hand by house Staff to the dining room where Staff had placed a tray of coffee cups, spoons, a pitcher of hot water, sugar and cream packets, coffee and hot cocoa packets on the dining room table. Client #8 was cued to sit at the table. Client #8 grabbed the pitcher full of hot water and began to drink out of it. Staff redirected Client #8 to put the pitcher down, removed the pitcher from the dining room, got a new pitcher of hot water and gave</p>	W 249			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 36</p> <p>Client #8 a coffee mug full of hot coffee to drink. Client #8 drank coffee from a regular coffee mug.</p> <p>2. Observation on 11/17/15 at 7:15 AM to 10:35 at 1020 House revealed Client #8 being led hand in hand by Staff to the dining room where she was cued to sit. Staff then put a protective covering around Client #8's neck, put cereal and milk in a small bowl for her and handed her a long handled spoon in her left hand, along with a cut away glass. Client #8 ate her cereal and drank her juice. Client #8 was not provided her adaptive dining dish. At 10:35 AM Client #8 was handed a small glass of apple juice and a bowl of Sun Chips. The dishes were not adaptive dining dishes.</p> <p>3. Observation on 11/18/15 at 1:25 PM at 1020 House revealed Client #8 was led by staff to the dining room table for coffee break. She was cued to sit at the dining table with four peers. Staff had placed a tray with items for coffee/cocoa on it (cream/sugar, mugs, spoons, hot water pitcher). Staff poured water into cups. Client #8 was handed a regular coffee mug with coffee in it. She drank it and then left the table. Client #8 was not offered her adaptive dining dishes.</p> <p>4. Observation on 11/19/15 at 9:55 AM at 1020 House revealed Staff K cued a peer to get Client #8 a glass of juice. The peer took Staff K's keys and brought a paper cup of apple juice to Client #8. Client #8 had difficulty drinking from the paper cup, squeezing it nearly spilling the contents. Staff K held the paper cup for Client #8 to drink from to avoid spilling the juice. Client #8 was not offered her adaptive dining dish to drink from.</p>	W 249			

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	Continued From page 37 Record review on 11/19/15 at 10:30 AM revealed Client #8's IHP dated 12/18/15 listed the following adaptive equipment to be used at meals; high-sided dish/plate, junior long handled fork and spoon, cut away glass and protective covering.  Interview on 11/19/15 at 2:50 PM with Staff S verified Client #8 should have used the adaptive dining equipment as written in her IHP for all meals and snacks.  Interview on 11/19/15 at 3:45 PM with Staff T verified Client #8 was assessed as needing specialized dining equipment. Staff T indicated Client #8 should be consistently using these pieces of dining equipment at every meal/snack in any setting she finds herself.	W 249			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION  The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.  This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to provide Active Treatment Schedules for 1 of 10 Sample Clients (Client #9) and 1 of 3 Expanded Sample Clients (Client #13) that directed staff on how and when to implement activities designed to teach independence over the course of the Clients' day. This failure prevented the Clients from having supportive staff who knew what activities to teach, and when to teach them to Clients throughout their day.	W 250		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 250	<p>Continued From page 38</p> <p>Findings included</p> <p>Client #9</p> <p>Record Review on 11/19/15 at 10:30 AM of Client #9's Comprehensive Functional Assessment (CFA) dated 3/12/15 and Active Treatment Schedule revealed an active treatment schedule that was generic including long periods of unstructured time or little activity e.g.: 8:00 AM - 11:00 AM prepare for work or day (work/leisure), 13:00 PM - 16:30 PM Leisure/Rec/Social. The CFA also stated that Client #9 was capable of a variety of household chores including washing dishes, sweeping and mopping floors, taking out the trash and handling laundry (i.e. take laundry out, load and unload washing machine/dryer, put away clean kitchen laundry, etc.) but formal training in this area was not currently indicated.</p> <p>Interview on 11/19/15 at 3:50 PM with Staff P and Staff Q revealed Client #9 spent large amounts of time doing nothing and he needed consistent structure to engage in activities in order to gain independence. Staff P admitted that 1:1 support staff need better training on how to best engage the Client's they are working with. Staff P indicated Client #9 should be consistently cued to serve himself his meals, encouraged to go off the house more and admitted that some activities (van rides) were more busy activities verses structured activities to increase client's chances to move to a less restrictive setting.</p> <p>Client #13</p> <p>Record review on 11/19/15 for Client #13 revealed an Active Treatment Schedule which instructed staff for the time periods of 9:00 AM to</p>	W 250			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 250	Continued From page 39 11:15 AM and from 12:15 PM to 3:30 PM with the following: "On/Off house activities" , " Sat-Sun-off house activities" and "Encourage to participate". There were no instructions on the schedule for the time period of "3:30 PM to 1700."	W 250			
W 252	Interview on 11/19/15 at 3:32 PM with Staff A and Staff B verified it was difficult to give staff a specific schedule and instruction on what to do with Client #13 over the course of the day because he often refused to engage in activities especially with newer staff.  483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 2 of 10 Sample Clients (Clients #7 and #8) and 1 of 3 Expanded Sample Clients (Client #12) had objectives with data in a form that would allow progress to be determined. This failure prevented the facility from being able to know how the Clients were progressing on their training objectives.  Findings include:  Client #7  1. Observations of Client #7 on 11/17/15 and	W 252		12/18/15	

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	<p>Continued From page 40</p> <p>11/18/15 revealed Client #7 had a 1:1 staff assigned. Client #7 bused his dishes and trash after breakfast and supper on 11/18/2015. Client #7 bused his dishes after breakfast on 11/17/15.</p> <p>Records review for Client #7 on 11/18/15 at 3:00 PM revealed Client #7's Individual Habilitation Plan (IHP) dated 3/17/15 had Objective #1128: "With initial cue, [Client #7's Name] will bus his dirty dishes to the kitchen with 80% or greater accuracy for six consecutive months." Data Sheets for Objective #1128 sheet stated "[Client #7's name] will set dishes on receiving area of the sink" and "[Client #7's name] will remove trash". Client #7's QIDP active treatment review for Objective #1128 stated "[Client #7's name] will independently rinse his dirty dishes with 80% accuracy for 6 months".</p> <p>Interview on 11/18/15 at 9:20 AM with Staff D verified that disposing of trash after meals was not included as part of the requirements of Objective #1128 in Client #7's IHP.</p> <p>Client #8</p> <p>1. Observation on 11/19/15 at 9:05 AM revealed Client #8 seated at her work station in Oakley House with Staff K seated on her right side. Staff K cued Client #8 to "push the button" numerous times before Client #8 leaned forward to press the button on the electric screw driver with her left hand before letting her hand fall to the side. Client #8 did not complete any other steps of the program during observation from 9:05 AM - 10:04 AM.</p> <p>Record review on 11/19/15 at 9:50 AM of Client #8's vocational file, total task program and data</p>	W 252			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	<p>Continued From page 41</p> <p>sheets for vocational objective #5142 revealed staff scored each of 4 phases at 1 of 4 levels of assistance. However, the review of the progress conducted by facility staff resulted in a single numerical score.</p> <p>The final score used by the facility to track progress did not provide an accurate measurement of Client #8's ability to complete the objective at the specified levels of assistance. Rather, it comprised a single score consisting of an average of Client #8's performance of each of the 4 separate phases within her vocational training plan.</p> <p>Interview on 11/19/15 at 9:50 AM with Staff K and on 11/19/15 at 3:50 PM with Staff M verified the facility's method of tracking data did not allow the facility to determine the amount of progress Client #8 made towards meeting her objective.</p> <p>Client #12</p> <p>Record Review of Client #12's file on 11/19/15 of Total Task Plans, data sheets, Monthly Person Responsible Reviews, and Qualified Intellectual Disability Professional Active Treatment Reviews revealed Objective #5146's data collection was not clear and measureable. Staff scored each of 4 phases using 1 of 4 levels of assistance. However, the review of the progress conducted by facility staff resulted in a single numerical score.</p> <p>The final score used by the facility to track progress did not provide an accurate measurement of Client #12's ability to complete the objective at the specified levels of assistance. Rather, it comprised a single score consisting of</p>	W 252			

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>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 252	Continued From page 42 an average of Client #12's performance of each of the 4 separate phases within his vocational teaching plan.	W 252			
W 255	Interview on 11/19/2015 at 3:30 PM with Staff AA, Staff D and Staff C verified data criteria for Client #12's objective #5146 did not provide clear measurable progress towards completion. 483.440(f)(1)(i) PROGRAM MONITORING & CHANGE  The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure that completed objectives in 2 of 10 Sample Clients (Client #7 and #9) Individual Habilitation Plans (IHP) were identified, modified or changed to meet the needs or accomplishments of the Client. This failure prevented Clients from having new needs identified and from obtaining new training skills.  Findings include:  Client #7  Records review for Client #7 on 11/18/15 at 3:00 PM revealed Client #7's Individual Habilitation Plan (IHP) dated 3/17/15 with Objective #2071 stated: "to express rejection appropriately with 95% accuracy for 10 of 12 months". Review of the Qualified Intellectual Disability Professional (QIDP) Active Treatment Review sheets revealed	W 255		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 255	Continued From page 43 Client #7 had met criteria for Objective #2071 since July of 2014 with 100% accuracy.  Interview with Staff D on 11/18/15 at 9:20 AM verified he was aware that Client #7 had exceeded the criteria for meeting Objective #2071, but he did not replace or update Objective #2071.  Client #9  Record review on 11/18/15 at 10:30 AM for Client #9's IHP dated 3/12/15 noted an adaptive replacement program #2083 as: [Client #9's first name] will initiate an appropriate social interaction with 80% or greater accuracy for 10 of 12 consecutive months. The Psychological Comprehensive Functional Assessment dated 3/12/15 reported a mean of 81% from March, 2014 to February, 2015. The QIDP Active Treatment Review noted from February, 2015 to August, 2015 that Client #9 scored higher than 85% accuracy.  Interview on 11/19/15 at 3:50 PM with Staff P, Staff Q and Staff R verified they were not aware of the consecutive scores reaching over 80% and that Client #9 had achieved the adaptive replacement objective # 2083.	W 255			
W 256	483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE  The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.	W 256		12/18/15	

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 256	<p>Continued From page 44</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 10 Sample Clients (Client #3) had his Individual Habilitation Plan (IHP) redone in response to a significant mental health crisis which significantly changed his behavior. Failure to redo the IHP in response to a significant change prevented the facility from aggressively meeting his current needs.</p> <p>Findings include:</p> <p>Client #3</p> <p>Interview on 11/18/15 at 9:40 AM with Staff C revealed Client #3 had a significant mental health decompensation episode early in the year. Since then staff had not pushed him because of his verbal outbursts and yelling.</p> <p>Review on 11/19/15 at 1:30 PM of Client #3's file revealed he had suffered a significant change in his functioning in [REDACTED] 2015. These changes resulted in a stay in the hospital and he returned to the facility in [REDACTED], 2015. At the time of returned to the facility, Client #3's behavior and functioning was significantly changed from prior to [REDACTED], 2015. Client #3's Comprehensive Functional Assessment (CFA) and Individual Habilitation Plan (IHP) were not redone as a result of this significant change in functioning.</p> <p>Interview on 11/19/15 at 3:30 PM with Staff D verified the facility had not redone the CFA or IHP as a result of this significant change in functioning. He verified the facility had dealt with the changes through Ad-Hocs (meetings with subsequent written changes) to the IHP that was</p>	W 256		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 256	Continued From page 45 in place prior to the change in functioning. The changes to objectives and programs consisted primarily of stopping programs. It was not until Client #3's regularly scheduled IHP date (9/3/15) that the CFA and IHP were redone to address the changed functioning of Client #3.	W 256			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE  At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update 1 of 10 Sample Clients' (Client #3) Comprehensive Functional Assessment (CFA) when he experienced a significant change in functioning due to a mental health crisis. Failure to update and change the CFA prevented the facility from having a clear picture of the Client's current strengths and weakness so that an Individual Habilitation Plan (IHP), which met the current needs, was developed.  Findings include:  Client #3  Interview on 11/18/15 at 9:40 AM with Staff C revealed Client #3 had a significant mental health decompensation episode early in the year. Since then staff had not pushed him because of his verbal outbursts and yelling.  Review on 11/19/15 at 1:30 PM of Client #3's file revealed he had suffered a significant change in	W 259	12/18/15		

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:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/20/2015</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)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 259	<p>Continued From page 46</p> <p>his functioning in [REDACTED] 2015. These changes resulted in a stay in the hospital and he returned to the facility in [REDACTED] 2015. At the time he returned to the facility, Client #3's behavior and functioning was significantly changed from prior to [REDACTED] 2015. Client #3's Comprehensive Functional Assessment (CFA) was not redone as a result of this significant change in functioning.</p> <p>Interview on 11/19/15 at 3:30 PM with Staff D verified the facility had not redone the CFA as a result of this significant change in functioning. He verified the facility had dealt with the changes through Ad-Hocs (meetings with subsequent written changes) to the IHP which was in place prior to the change in functioning. He verified that a new CFA was not done until Client #3's regularly scheduled IHP date (9/3/15) occurred.</p>	W 259			