

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

8802

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/21/2013
NAME OF PROVIDER OR SUPPLIER  RAINIER SCHOOL PAT C			STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS  This report is the result of a Complaint Investigation (2771523/2772673) conducted at Rainier School PAT C on 03/21/13. A sample of 1 of 1 residents was selected.  The survey was conducted by:  ██████████ R.N., B.S.N. ██████████, M.A.  The survey team is from:  ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Services Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600  Telephone: (360) 725-2405 Fax: (360) 725-2642	W 000			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on record review and interview facility staff failed to report allegation of Neglect for 1 of 1 Residents (Resident #1) to facility	W 153	W 154 Staff Treatment of Clients  Rainier School will continue to report  Any allegations of neglect, mistreatment or abuse as well as  injuries of unknown source to the administrator  Or to other officials in accordance with State law through established procedures.  PERSON RESPONSIBLE: DDA/DDA2  MONITOR: ADMIN	inging 9/22/13	

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

*[Signature]*

TITLE

*[Signature]*

(X6) DATE

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

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/21/2013
NAME OF PROVIDER OR SUPPLIER  RAINIER SCHOOL PAT C			STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	Continued From page 1 administration and CRU (Complaint Resolution Unit) in a timely manner. This failure did not provide protection for the resident during that four day period which could have led to further harm. Record review revealed on 03/07/13 Staff A arranged for Residents on Rainier School PAT C for movie night. Resident #1 (from 1050 cottage) is on enhanced supervision (line of sight) when he is not on the cottage unless in the bathroom. Record review revealed Staff C (janitor who cleaned up after movie night) reported the incident on 03/11/13 to the facility QIDP (Qualified Intellectual Disability Professional) when he came back to work that afternoon. Staff C had Friday, Saturday, and Sunday 's off. Staff C told the QIDP that Resident #1 asked "Where is everybody?" when he came out of the bathroom. Staff C did not recognize Resident #1 and told him to go home. Resident #1 stated that he had to go to the bathroom before the movie finished and when he came out there was no one there. Resident #1 stated that he started back to the cottage and met Staff A when he was going down the hall (in the administrative building). Resident #1 stated that he was not scared and stated that he knew how to find his way back to the cottage. Resident #1 was unable to give much more information regarding the incident other than he liked the movie. Staff A, who is from 1050, the same cottage as Resident #1, was interviewed on 03/21/13 and stated that on 03/07/13 there were 16-18 residents that attended the movie in the gym. Staff A stated that there were four staff total that were monitoring the residents during the movie. When the movie ended the residents that were independent headed back to their cottages. Staff	W 153	Campus wide email to staff noting that they are encouraged to report incidents of unusual circumstances during non-business hours to the Duty Office  PERSON RESPONSIBLE: DDA/DDA2  MONITOR: ADMIN	4/22/13	

ALM  
4/22/13

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50G047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/21/2013
NAME OF PROVIDER OR SUPPLIER  RAINIER SCHOOL PAT C			STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	Continued From page 2 A stated that he had to call one of the cottages to come and get their residents and he started to stack and put away the furniture in the gym so that it was ready when the janitor (Staff C) showed up. Staff A stated that he was unaware that Resident #1 had gone to the bathroom so when he was done cleaning up and putting things away he went back to his cottage (1050). When he got back to the cottage he asked if Resident #1 was back. Staff informed Staff A that resident was not in the house. Staff A checked Resident #1's room and started back to the gym to see if resident was there. When he was going through the door between the PAT C administrative offices and the gym, Staff A observed Resident #1 coming through the double doors toward him. Staff A stated that he was very relieved that Resident #1 was okay and then escorted him back to the cottage. Staff A did not report this incident to the AC 3 (Attendant Counselor) on shift nor did he report it to administration. Staff B, who is from 1050, the same cottage as Resident #1, was interviewed on 03/21/13 and stated that on 03/07/13 he had assisted with the movie and then took some of the residents back to their cottage (1050). Staff B stated that he did not know that anyone was missing until Staff A came back to the cottage and asked where Resident #1 was. Staff B was asked what the protocol for reporting a missing resident, Staff B stated that he would notify the AC3 (Attendant Counselor 3) and document in the residents file. Staff B was asked if he had done this when he knew that resident was missing. Staff B stated that he did not notify the AC3 nor document because the resident was found. Staff B stated that he should have notified the AC3 and documented in the residents file. Staff B did not	W 153			

ALM  
4/22/13

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/21/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD BUCKLEY, WA 98321</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 3 notify the AC3 or administration regarding the incident.	W 153		
W 285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to provide sufficient supervision to ensure that the safety and welfare of 1 of 1 Residents (Resident #1). Failure to provide sufficient supervision for Resident #1 allowed resident to be left behind in the gym after a movie viewing event.</p> <p>Record review and interview revealed that Resident #1 is on a protective supervision when not on the cottage. Resident #1 is to be within line of sight of staff at all times unless in the bathroom. Resident #1 was left alone after having to use the bathroom during the end of the movie. Staff A did not check the bathroom after the movie to ensure that residents were not in there when the movie concluded. the staff and residents returned to their cottages after the movie ended and the area had been cleaned up. Per residents IHP (Individual Habilitation Plan) Resident #1 is on the enhanced supervision while</p>	W 285	<p>W285 MANAGEMENT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Staff A and B will be re-in serviced on Client 1's Behavior Support Program</p> <p>Staff A and B received disciplinary action for their failure to report incident</p> <p>PERSON RESPONSIBLE: ACM MONITOR: DDA2</p> <p>Staff C in-serviced on procedures for notifying the Duty Office of unusual events during non-business hours</p> <p>PERSON RESPONSIBLE: DDA1 MONITOR: DDA2</p>	<p>4/24/13</p> <p>3/28/13</p> <p>3/28/13</p>

*AM*  
*4/22/13*

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/21/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD</b> <b>BUCKLEY, WA 98321</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 285	Continued From page 4 off the house due to potential of being [REDACTED] with other residents and is accompanied off the house for this reason. Resident #1 had been without the supervision for greater than 30 minutes before staff realized that resident did not return to the cottage with the others.	W 285			

*ALM*  
*9/22/13*