**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**

R-C 02/28/2020

**NAME OF PROVIDER OR SUPPLIER**

RAINIER SCHOOL PAT C

**STREET ADDRESS, CITY, STATE, ZIP CODE**

RYAN ROAD
BUCKLEY, WA 98321

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**COMPLETION DATE**

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**INITIAL COMMENTS**

This report is the result of a follow up visit for Complaint Investigation 3691354 at Rainier School PAT C.

The investigation occurred on 02/25/20 and 02/28/20.

Failed provider practice was identified and the Immediate Jeopardy was not removed.

The survey was conducted by:

Linda Davis
Arika Brasier
Patrice Perry
Justin Smith
Gerald Heilinger

The survey team is from:

Department of Social & Health Services
Aging and Long-Term Support Administration
Residential Care Services, ICF/IID Survey and Certification Program
PO Box 45600, MS: 45600
Olympia, WA 98504

Telephone: 360-725-3215

**GOVERNING BODY**

CFR(s): 483.410(a)(1)

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:

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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.
Based on record review and interview, the facility failed to take necessary actions to remove an Immediate Jeopardy when they did not ensure Direct Care Staff (DCS) were deployed in a manner that could meet the supervision, protection, and care needs of Clients as determined necessary by the facility’s assessments for three of six Sample Houses (1010 Quinault Court (QC), 1040 QC, and 1050 QC). The facility failed to ensure their directions to staff for their Posts (a designation used by the facility for how they assigned Clients to staff for the shift) were current and accurate. This failure resulted in Clients continuing to be at risk for health and safety concerns (e.g. Clients going missing, at risk of abuse from other Clients, or injury from self-injurious behavior), and resulted in the continuance of the Immediate Jeopardy.

Findings included...

1. Review of the Statement of Deficiencies (SOD) written for the 02/05/20 Complaint Survey (ASPEN Event ID (D9ZU11) showed: Complaint Resolution Unit (CRU) Intake 3691360, called in at 9:03 PM on 02/20 by the facility; Client #34 was last seen around 6:00 PM that night; and the facility Superintendent stated that as of 02/05/20 Client #34 had not been located.

The SOD showed citations were written for W104 - Governing Body, W186 - Facility Staffing, and W234 - Program Directions.
The SOD showed the deficiencies constituted an Immediate Jeopardy.

Under W186 the SOD showed the facility did not deploy sufficient numbers of DCS to 2015 QC House to ensure those staff could meet the needs of the Clients living at the house. The SOD showed circumstances related to times when a DCS would be on their designated lunch break and the remaining staff would not be able to meet the needs of the Clients assigned to their care. Client #34 left the house during one of these situations.

Under W234 the SOD showed the facility did not ensure DCS were given clear directions on how to provide for the needs of the Clients assigned to their care. In some cases there were no directions written for a Post. In other cases, the directions did not include instructions for the Clients assigned to the post.

During an interview on 02/28/20 at approximately 8:15 AM, Staff A, Superintendent, stated that Client #34 had not been found, was removed from the facility census, and was listed as a missing person by law enforcement.

2. Review on 02/25/20 of the corrections made by the facility to remove the Immediate Jeopardy showed the facility had assigned an additional DCS to 2015 QC House (bringing it to a level of seven staff on a regular basis for both AM and PM shifts) and there were six post assignments
Continued From page 3 involving Client care. This arrangement allowed for coverage of posts when DCS were on their assigned break. It showed the facility was still assigning a DCS from the house to the facility’s emergency Behavior Response Team (BRT) several days a week. (BRT was used to handle Clients having behavior management problems that could not be handled by the DCS at the house. This required any DCS assigned to BRT to leave their post to respond to the emergency.) The house was still on the schedule to give up a DCS if another house had DCS not show up for work. With these potential situations of removing DCS from the house and care of the Clients, the facility was told the Immediate Jeopardy was not removed.

3. Review on 02/28/20 of the staffing situation at 2015 QC House showed the facility had removed the house from covering BRT and the house was removed from sending a staff to cover other houses who had DCS not show up for work that day. The facility did not make changes to the system of BRT or staff shortage coverage for any of the other houses.

4. Record review of facility Standard Operating Procedure 2.11 Behavior Response Team, issued December 3, 2019, showed the duties of a DCS assigned to BRT were to respond to the crisis immediately. No options for not responding to a BRT call were noted.

During an interview on 02/28/20 at 4:29 PM, when asked how coverage of Posts would work
When a DCS was assigned to BRT and a DCS was on their assigned break, Staff A stated that a house which did not have the required number of staff for a shift would not have a staff assigned to BRT for that shift. Staff A also stated that according to facility policy a staff assigned to BRT duties would not have to respond to a call if circumstances at their house would prevent them from leaving.

Record review of the Staff Communication Sheet for 1050 QC House for 02/28/20 showed it was to have five staff assigned that day but only four staff were assigned to AM shift. One of those four staff was assigned to BRT for that shift.

Record review of the BRT log for the facility showed there were 23 calls for January, 2020 and 10 in February, 2020 (through the 23rd).

Review of facility records on 02/25/20 showed seven staff had been assigned to 2015 QC. Review of the directions to staff in the Post Book for 2015 QC showed it contained directions for only six post positions.

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to make substantive changes to their system for providing Direct Care Staff (DCS) assignments to the houses to ensure the needs of the Clients were met for three of six Sample Houses (1010 Quinault Court (QC), 1040 QC, and 1050 QC). The facility did not ensure needs would be met: when they assigned DCS to provide care and supervision to more than one Client; when one or more of the Clients required the DCS to keep a Client/s under line of sight (LOS) supervision; when one or more of the Clients engaged in behaviors that then would require the staff to provide exclusive attention to that Client preventing them from meeting the needs of the other Clients assigned to their care; when there were insufficient numbers of staff during assigned DCS lunch breaks; and when there were insufficient numbers of staff during times when a staff left the house for facility’s emergency Behavior Response Team (BRT). This failure resulted in all Clients being at risk for not having their assessed needs being met and put some at risk of health and safety concerns.

Findings included...

1040 Quinault Court House
AM Shift
Record review of Post 1 AM Assignment Sheet showed they were responsible for Client #12,
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat C  
**Address:** Ryan Road, Buckley, WA 98321

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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| {W 186}       | Continued From page 6  
Client #13, and Client #14.  
Record review of Client #12's Positive Behavior Support Plan (PBSP), dated 11/21/19, showed:  
-She had a behavior of physical aggression and required staff to get between her and her peers when she was being aggressive.  
Record review of Client #13’s IHP, 11/14/19, showed:  
-No special supervision concerns and that he was independent and had no mobility deficits.  
Record review of Client #14’s Individual Habilitation Plan (IHP), dated 01/29/2020, showed:  
-He was on Protective Supervision (PRO) and staff must keep him in their line of sight both on the house and off the house.  
An example of how Post 1 could not meet the needs of their assigned Clients, would include but not be limited to:  
If Client #12 attempted to aggress towards another Client and the staff in Post 1 intervened, they would not be able to provide line of sight supervision to Client #14 if he went to another area of the house.  
Record review of Post 2 AM Assignment Sheet showed they were responsible for Client #15, Client #16, and Client #17.  
Record review of Client #15’s IHP, dated 12/23/19, showed:  
-He used a wheelchair to ambulate both on and off grounds.  
-He required staff to remain in the room with him | {W 186} |
Continued From page 7

to supervise when he bathed and required "max physical assistance" to complete all parts of bathing.

- He was on variable PRO (staff were to determine the level of distance from within arm’s reach to no further than line of sight based on aggressive behaviors) if he was in a continued agitated state. A continued agitated state was defined as aggressive behavior towards others, refusal to walk safely or use a gait belt (a device put on a Client who had mobility issues to assist in safely moving them) and self-harm with continuously dropping to the floor.

Record review of Client #16’s IHP, dated 05/21/19, showed:
- He was tracked for the following behaviors: physical aggression, disruptive behavior, inappropriate toileting, verbal aggression, and non-reality behavior. He did not have enhanced supervision needs.

Record review of Client #17’s IHP, dated 08/22/19, showed:
- She was placed on PRO line of sight when she engaged in physical aggression towards others, property destruction, and for going off campus without staff.

An example of how Post 2 could not meet the needs of their assigned Clients, would include but not be limited to:

If Client #15’s assigned staff assisted him with bathing, they would not know if Client #17 engaged in behavior which would require her to be on PRO line of sight.
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<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>{W 186}</td>
<td>Continued From page 8 Record review of Post 3 AM Assignment Sheet showed they were responsible for Client #18 and Client #19. Record review of Client #18's IHP, dated 02/05/20, and stamped &quot;DRAFT&quot; showed: - He was blind and had a significant hearing deficit. He required staff assistance for toileting, bathing, dental and personal hygiene. Record review of Client #18's PBSP, dated 02/05/20, marked &quot;DRAFT&quot;, showed: - He had the following behaviors to be decreased: self-injurious behavior defined as striking his head with his hand or intentionally hitting his head against hard objects and aggression defined as scratching, pinching, hitting, kicking, and pulling the hair of others. Staff were to &quot;cue/deflect- stop/redirect&quot; if he engaged the behaviors. Record review of Client #19's IHP, dated 05/09/19, showed: - He was blind and required a staff nearby when he navigated, at all times. An example of why Post 3 could not meet the needs of their assigned Clients, would include but not be limited to: If Client #18 was engaged in self-injurious behavior their DCS could not intervene if they needed to be nearby Client #19 when he chose to navigate. Record review of Post 4 AM Assignment Sheet showed they were responsible for Client #20,</td>
<td>{W 186}</td>
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Client #21, and Client #22.

Client #20's IHP, dated 05/16/19, showed:
- Staff needed to do environmental checks of his area each time he moved to a different locations to ensure no food or drink out of his prescribed diet was present. He required staff to be within arm's reach when he was around food.

Record review of Client #21's IHP revision, dated 02/19/20, showed:
- He had eluded staff members by leaving his house since his admission on [redacted]/19. He also had a history of elopement prior to being admitted to the facility.
- His supervision was PRO line of sight when he was at his house from the hours of 6:15AM to 8:15 PM.
- Staff could be within arm's reach to provide him assistance, redirect behaviors, and when he left his house.

Record review of Client #22's IHP, dated 07/22/19, showed:
- He did not have enhanced supervision but he used a wheelchair. When he left his house he would need assistance transporting himself.
- He would need staff to provide stand-by assistance when toileting.

An example of why Post 4 could not meet the needs of their assigned Clients, would include but not be limited to:

If Client #21 left the House the DCS would have to follow putting Client #20 and #22 at risk given their stated needs above.
Record review of Post 5 AM Assignment Sheet showed that they were responsible for Client #23.

Record review of Client #23’s IHP, dated 04/30/19, showed:
- During waking hours AM/PM, he had variable PRO line of sight on house and within 5 feet off house.
- When he was around food he needed staff to be within arm’s reach.

Record review of Post 6 AM Assignment Sheet showed that they were responsible for Client #24.

Record review of Client #24’s IHP, dated 01/23/20, showed:
- He was PRO line of sight both on and off of the house.

Record review of Client #24’s PBSP, dated 01/23/20, showed:
- He had the following challenging behaviors to be decreased: agitation defined increased restlessness and pacing, self-injurious behavior defined as slapping, hitting and banging his head or abdomen with his fist or against hard objects and scratching, elopement defined as attempts to or exiting the facility grounds.

Record review of Post 7 AM Assignment Sheet showed it was not assigned specific Clients.

PM Shift

All of the needs listed in IHP’s and PBSP’s for Clients at 1040 House remained the same as AM
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<td>(W 186)</td>
<td>Continued From page 11 shift.</td>
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<td>Record review of Post 1 PM Assignment Sheet showed they were responsible for Client #12, Client #13, and Client #14.</td>
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<td>An example of why Post 1 could not meet the needs of their assigned Clients, would include but not be limited to: The DCS would not be able to provide the supervision needed for Client #14 and care for the needs of Client #12 and Client #13 if Client #14 chose to leave the house.</td>
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<td>Record review of Post 2 PM Assignment Sheet showed they were responsible for Client #20, Client #21, and Client #22.</td>
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<td>An example of why this Post 2 could not meet the needs of their assigned Clients, would include but not be limited to: The DCS would not be able provide line of sight supervision at all times to Client #21 as well as meet the needs of Client #20 and Client #22.</td>
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<td>Review of the 1040 Post Position Book for PM shift showed it did not contain a Post Three Assignment.</td>
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<td>Record review of Post 4 PM Assignment Sheet showed they were responsible for Client #16, Client #17, and Client #18.</td>
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<td>An example of why Post 4 could not meet the needs of their assigned Clients, would include but not be limited to:</td>
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The DCS would not be able to provide the necessary care needs for Clients if Client #16 was engaging in physical aggression, Client #17 was placed on line of sight for property destruction, and if Client #18 began engaging in self-injurious behaviors.

Record review of Post 5 PM Assignment Sheet showed that they were responsible for Client #15 and Client #19.

An example of why Post 5 could not meet the needs of their assigned Clients, would include but not be limited to:

The DCS would not be able to provide for Client #15’s supervision needs if he went on enhanced supervision due to continued agitation and provide care for Client #19 if he wanted to navigate his environment.

Record review of Post 6 PM Assignment Sheet showed that they were responsible for Client #23.

Record review of Post 7 PM Assignment Sheet showed that they were responsible for Client #24.

During an interview on 02/28/20 at 3:10 PM, Staff E, Attendant Counselor Manager (ACM), Staff F, Qualified Intellectual Disabilities Professional (QIDP), Staff G, Psychology Associate (PA), and Staff H, Developmental Disabilities Administrator 1, stated that the basic staffing level on 1040 House was seven. They stated that the IHP’s and PBSP’s for Clients were current. They stated that they felt the Post assignments could meet the Clients’ needs with one DCS. They stated it was
Continued From page 13

extremely rare for more than one Client at a time
to engage in a behavior.

1040 Quinault Court House working short staffed

Record review of facility's Basic Care Levels
sheet, dated 02/22/20, showed that the staffing
level for 1040 House was seven for both AM and
PM shift.

Record review of the facility's Behavior Response
Team (BRT) Schedule for AM & PM shifts,
undated, showed 1040 House was scheduled for
BRT on Sundays, Wednesdays, and Saturdays.

Record review of a Duty Office Staffing sheet,
dated 02/26/20, showed that six staff worked the
PM shift. One of the staff who worked on the PM
shift at 1040 House was assigned to the BRT and
would have to abandon their Post to respond if
an emergent incident occurred.

During an interview on 02/28/20 at 4:29 PM, Staff
A, Superintendent, stated that if a House was
short staffed (under the minimum assigned) they
would not be assigned to BRT that shift.

1050 Quinault Court House

Record review of the facility's Basic Care Level
Sheet, dated 02/28/20, showed 1050 House was
assigned five staff to meet the needs of their
Clients.

Record review of the BRT and Fire Team
Schedule for AM and PM Shifts showed 1050
### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier/CLIA Identification Number:

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<tr>
<td>50G047</td>
<td>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</td>
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#### Date Survey Completed:

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#### Name of Provider or Supplier:

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<th>NAME OF PROVIDER OR SUPPLIER</th>
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<tr>
<td>RAINIER SCHOOL PAT C</td>
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#### Street Address, City, State, Zip Code:

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<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<td>RYAN ROAD BUCKLEY, WA 98321</td>
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House was assigned to BRT on Sundays, Wednesdays, and Fridays.

Record review of 1050 House showed it had five staff assigned for AM and PM shifts. 1050 House had 5 Post assignments.

1. This left no staff to cover breaks or emergencies. Staff would have to abandon their Post or have a co-worker take over the responsibility of their Post, so they could use the restroom.

2. When 1050 House was assigned to the BRT, staff would have to abandon their Post to go assist in the emergency. This left the remaining staff to cover the abandoned Post. 1050 House was assigned to the BRT on Sundays, Wednesdays, and Fridays.

3. The inappropriate behaviors (sexual and physical aggression) associated with seven Clients in 1050 House present a clear and present risk to other Clients if not supervised.

Record review of Rainier School Staff Communication sheet for 1050 House, dated 02/28/20, AM shift showed 1050 House only had four DCS. One staff was assigned to BRT. If the Staff left on a BRT call, it required the three remaining DCS to complete all the duties and responsibilities of all five Posts. This situation provided no coverage for staff lunches or bathroom breaks.

Record review of Rainier School Staff Communication sheet for 1050 House, dated 02/26/20, PM Shift showed the house had only four DCS. This forced the four staff to cover all...
Continued From page 15

the duties and responsibilities of all five Posts. This situation provided no coverage for staff lunches or bathroom breaks.

During an interview on 02/28/20 at 4:29 PM, Staff A, Superintendent, stated that they had a process for when houses ran short staffed. If a house was operating below the necessary staff number, they would not be assigned to BRT.

Record review of 1050 House Post assignments showed:
Post 1 - Client #1 and Client #2
 Record review of Client #1’s IHP, dated 09/10/19, and PBSP, dated 11/23/19, showed:
- Client #1 received the standard supervision from the staff who worked his post rotating attention to all the other clients covered by that post.
- Client #1 received Line of Sight (LOS) PRO off house due to a history of sexually victimizing "lower functioning" male peers.
- Client #1 had on and off house line of sight PRO following incidents of sexual activity.
- Client #1 had a history of elopement.
- Staff would check on him every 30 minutes during waking hours to make sure he was still on the house. Staff would document when the checked on him.

Record review of Client #2's IHP, dated 11/14/19, and PBSP, dated 11/26/19, showed:
- Client #2 did not have any special
Continued From page 16

supervisory requirements when he was on or off the house.

- Client #2 required staff to redirect him to a quiet area when he engaged in verbal aggression.

- Staff were required to deflect Client #2's behavior using Therapeutic Options (a comprehensive approach to reducing violence and the use of restraint and seclusion in behavioral health care, health care, habilitation, and education settings. The program provides the tools to keep people safe while maintaining their commitment to positive approaches in supporting individuals whose behavior sometimes poses danger to themselves or others) when he engaged in physical aggression.

This Post presented a supervision or care problem when Client #2 engaged in physical aggression and Client #1 attempted to leave the house at that time. A staff could not supervise both Clients during this situation.

Post 2 - Client #3 and Client #4

Record review of Client #3's IHP, dated 05/28/19, and PBSP, dated 06/24/19, showed:

- He had LOS PRO when he was off the house.

- If Client #3 engaged in elopement or inappropriate sexual behavior he would be placed on LOS supervision on house. That supervision would continue until an investigation was completed.

- Staff were required to intervene when Client
This Post presented a supervision or care problem when both Clients need to leave the house or eloped off the house. A staff could not provide LOS PRO for two Clients in different locations on campus.

Post 3 - Client #5, Client #6 and Client #7.
Record review of Client #5's IHP, dated 08/29/19, and PBSP, dated 09/27/18, showed:
- He had no special supervisory requirements when he was on or off house.
- Staff needed to assist Client #5 to keep his

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<td>#3 was seen engaged in a sexual activity with a peer.</td>
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<td>Record review of Client #4's IHP, dated 04/04/2019 and PBSP, dated 06/25/19, showed:</td>
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<td>- He had LOS protective supervision off house.</td>
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<td>- Client #4 had the potential to get lost due to dementia symptoms.</td>
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<td>- Client #4 needed staff assistance monitoring his diabetic care/diet.</td>
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<td>- Client #4 had a history of eloping and the behavior was being tracked. Staff would check on Client #4 every 30 minutes and document those checks.</td>
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<td>- Client #4 - LOS off house supervision for sexually inappropriate behavior, dementia, risk of falls and aggression.</td>
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<td>- He needed assistance with ADLs and incontinence.</td>
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<td>This Post presented a supervision or care problem when both Clients need to leave the house or eloped off the house. A staff could not provide LOS PRO for two Clients in different locations on campus.</td>
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<td>Record review of Client #5's IHP, dated 08/29/19, and PBSP, dated 09/27/18, showed:</td>
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<td>- He had no special supervisory requirements when he was on or off house.</td>
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<td>- Staff needed to assist Client #5 to keep his</td>
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Room sanitary.

- He had frequent incontinence and would hide soiled clothing.

- If Client #5 refused to sanitize his room, staff must do it for him.

- Staff would intervene, if Client #5 engaged in aggression towards a peer or other staff, using Therapeutic Options.

Records review of Client #6’s IHP, dated 01/17/19, and PBSP, dated 01/23/19, showed:

- He did not have any special supervisory requirements on or off house.

- Client #6 had a history of tampering with electrical equipment and accessing unsafe areas.

- If staff smelled urine in his bedroom, they must verbally cue Client #6 to clean up his mess and ensure he completed the task.

Record review of Client #7’s IHP, dated 12/12/19, showed:

- He did not require any special supervisory requirements on or off the house.

- Staff needed to monitor Client #7 for frequent licking of random items, rectal digging, and rummaging through the trash.

This Post presented a supervision or care problem when Client #5 engaged in aggressive behavior. A staff couldn’t protect Clients from Client #5’s aggression and keep an eye on Client #7 to prevent him from licking items, rectal
Continued From page 19
digging or rummaging through the trash, which posed a threat to his health.

Post 4 - Client #8, Client #9 and Client #10.
Record review of Client #8's IHP, dated 07/16/19, and PBSP, dated 10/14/19, showed:
- He required no special supervision on or off house.
  - Staff needed to assist Client #8 in all activities of daily living to ensure thoroughness.
  - Staff needed to physically intervene when he engaged in physical aggression.
  - Two Staff were needed to place Client #8 in 2 person seated hold (A physical restraint to safely de-escalate the Client).
  - If two staff were not available, BRT should be called.

Record review of Client #9's IHP, dated 12/12/19, and PBSP, dated 02/13/19, showed:
- He required no special supervision on or off house.
  - If Client #9 went a period of 15 minutes where he did not respond to staff that would be defined as a psychotic episode.
  - Staff would then need to provide extra time and support for Client #9 to complete his ADLs.

Record review of Client #10's IHP, dated 02/28/19, and PBSP, dated 07/16/19, showed:
- He required LOS PRO off the house.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

50G047

**Date Survey Completed:**

02/28/2020

**Name of Provider or Supplier:**

RAINIER SCHOOL PAT C

**Street Address, City, State, Zip Code:**

RYAN ROAD
BUCKLEY, WA 98321

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
</table>

Continued From page 20

- He could travel to some locations independently, but staff had to use a phone check system to ensure he arrived at the specified location.

- If Client #10 was verbally aggressive with a peer, staff needed to stand in between the Clients.

This Post presented a supervision or care problem when Client #8 engaged in physical aggression. A staff could not provide extra time for Client #9 when a psychotic episode occurred or if Client #10 left the house.

Post 5.

- Record review of Client #11’s IHP, dated 05/02/19, and PBSP, 05/6/19, showed:
  - He required LOS PRO at all times.

- Staff must ensure Client #11 did not aggress towards his peers or destroy property. Staff may be required to place Client #11 in a Secure Escort Seated restraint.

- If the house did not have sufficient staff, BRT should be called to assist with the Secure Escort Seated restraint.

During an interview on 02/28/20 at 2:51 PM Staff B, (ACM), Staff C, (QIDP), and Staff C, Psychology Associate, stated that all of the Clients’ IHPs, PBSPs, and IHP revisions obtained were correct, up to date, and accurately described the needs of the Clients. They confirmed the Post assignments were up to date and contained all the information needed to
A. BUILDING __________________________
B. WING _____________________________

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>{W 186}</td>
<td>Continued From page 21 supervise the Clients in each Post.</td>
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<td></td>
<td>1010 QC House</td>
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<td></td>
<td>Record review of the facility's Basic Care Levels, dated 02/26/20, showed six staff were assigned to 1010 QC House. Three of those staff were dedicated to three Clients for their 1:1 supervision levels.</td>
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<td>Record review of the BRT &amp; Fire Team Schedule for AM &amp; PM Shifts, undated, showed 1010 QC House was scheduled for BRT on Mondays and Thursdays.</td>
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<td>Post 1:</td>
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<td>Record review of Post 1 on AM shift showed it was a Kitchen and Shift Charge position without assigned Clients. If the house was short staffed, the Shift Charge would then cover Post 2. This Post was responsible for kitchen duties and provided 15 minute breaks.</td>
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<td>Post 2:</td>
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<tr>
<td></td>
<td>Record review of Post 2 on AM shift showed this Post was responsible for Clients #25, #26, and #27. Post 2 could also be responsible for Client #31 in certain situations.</td>
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<tr>
<td></td>
<td>1. Record review of Client #25's IHP, dated 03/06/19, and IHP Revision, dated 01/03/20, showed:</td>
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<tr>
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<td>- He required staff support for mobility guidance when he left the house and used a wheelchair for transport when he had balance issues.</td>
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<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
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2. Record review of Client #26's IHP, dated 06/06/19, showed:  
   - He required verbal cues up to physical assistance with his Activities of Daily Living (ADLs).

3. Record review of Client #27's IHP, dated 06/26/19, showed:  
   - He used a wheelchair and needed staff assistance with transportation when he left the house.  
   - He required verbal cues up to physical assistance with all of his ADLs.

During an interview on 02/28/20 at 1:50 PM, Staff I, ACM and Staff J, QIDP, stated that Clients #25, #26, and #27's IHPs, and IHP Revisions were current and accurate.

An example of why Post 2 could not meet the needs of their assigned Clients, would include but not limited to: when Client #27 left the house, Staff could not provide care or supervision for Clients #25, #26, or #31, if assigned to the post.

Posts 3 and 4:

Record review of Post 3 and Post 4 on AM shift showed these Posts were responsible for Clients #28 and #29. Post 3 had Client #28 for the first half of the shift and Client #29 for the second half of the shift. Post 4 had Client #29 for the first half of the shift and Client #28 for the second half of the shift.
1. Record review of Client #28’s IHP, dated 12/23/19, and PBSP, dated 12/23/19, showed:
   - He required 1:1 line of sight protective supervision (PRO staff within 15 feet) 24 hours a day.
   - He required 1:1, PRO (staff within arm's length and able to intervene as needed when Client #28 was near liquids he could drink).
   - Client #28's challenging behaviors included physical aggression with intent to harm others (including throwing property and turning furniture over), self-injurious behavior (SIB), and inappropriate acquisition of items not in his diet.
   - He required verbal cues up to physical assistance with all of his ADLs.

2. Record review of Client #29's IHP, dated 11/05/19, and PBSP, dated 11/05/19, showed:
   - He required 1:1, PRO (staff within 15 feet when calm).
   - He required 1:1, PRO (staff in between Client #29 and other Clients when he was agitated).
   - Client #29's challenging behaviors include agitation, physical aggression with intent to harm others and elopement with attempting to or actually eluding staff supervision.
   - He required full physical assistance with his ADLs.
During an interview on 02/28/20 at 10:50 AM Staff J, QIDP and at 10:52 AM, Staff I, ACM stated that Clients #28 and #29's IHPs, IHP Revisions, and PBSPs were current and accurate.

Post 5:
Record review of Post 5 on AM shift showed this Post was responsible for Clients #30, #31, and #32.

1. Record review of Client #30's IHP, dated 04/23/19, IHP Revision, dated 02/14/20, and PBSP, dated 04/23/19, showed:
   - He required PRO (when engaged in challenging behaviors in the house).
   - He required PRO (staff within 10 feet) when not at the house.
   - He required PRO (staff in between Client #30 and other Clients when he was agitated).
   - Client #30's challenging behaviors included escalating inappropriate sexual behaviors which escalated to physical aggression to gain staff attention, inappropriate sexual behavior, and physical aggression.
   - Triggers to challenging behaviors included: downtime; staff being busy with others; work being cancelled; and not having activities planned.
   - He required verbal cues for some of his ADL's...
Continued From page 25

2. Record review of Client #31's IHP, dated 11/12/19, IHP Revision, dated 12/02/19, and PBSP, dated 11/12/19, showed:
   - He required PRO (staff within 15 feet) at all times.
   - He required PRO (staff within arm's reach and between Client #31 and other Clients) when agitated.
   - Client #31's challenging behavior was physical aggression and he may throw items at others.
   - He required full physical assistance and some verbal cueing for his ADLs.

3. Record review of Client #32's IHP, dated 12/11/19, showed:
   - He had a history of elopement prior to being admitted to Rainier School in [redacted] of 2019.

   During an interview on 02/28/20 at 10:45 AM and 10:48 AM Staff I, ACM and Staff J, QIDP, and at 1:50 PM, Staff I, ACM, stated that Clients #30, #31, and #32's IHPs, IHP Revisions, and PBSPs were current and accurate.

   In this situation, Post 5 was required to provide PRO for Client #31 and would be unable to provide care and needs for Clients #30 and #32.

Post 6:
Continued From page 26

Record review of Post 6 on AM shift at 1010 QC showed this Post was responsible for Client #33.

1. Record review of Client #33's IHP, dated 06/26/19, and PBSP, dated 06/26/19, showed:
   - He required 1:1 supervision (line of sight) on AM and PM shifts.
   - He required PRO (on night shift).
   - He required PRO (staff between Client #33 and other Clients) when agitated.
   - Client #33's challenging behaviors included verbal and physical aggression, eluding staff supervision, public masturbation, and disrobing.

During an interview on 02/28/20 at 10:50 AM, Staff I, ACM stated that Client #33's IHP and PBSP was current and accurate.

During an interview on 02/28/20 at 11:05 AM, Staff I, ACM, stated that the Post book was current and accurate.

INDIVIDUAL PROGRAM PLAN
CFR(s): 483.440(c)(5)(i)

Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the directions for
| {W 234} | Continued From page 27 supervision and care to meet the Clients' needs, were clear, concise, and accurate for one Sample House (2015 Quinault Court) was assigned seven staff for their AM and PM shifts. They only had descriptions for six of the seven staff Posts. This failure put Clients at risk of not receiving the necessary supervision or care their assessments identified. Record review of 2015 Quinault Court's Post Assignment book on 02/25/20 showed they only had descriptions for six of their seven staffing positions on the house. During an interview on 02/25/20 at 3:05 PM, Staff K, Program Area Team Director, stated that the 2015 Quinault Court House's Post book did not contain duties for all of the staff assigned to the house. | {W 234} |