# Statement of Deficiencies and Plan of Correction

## Provider/Supplier/CLIA Identification Number:

50G046

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## Date Survey Completed:

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## Name of Provider or Supplier:

RAINIER SCHOOL PAT E

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

320 RYAN ROAD

BUCKLEY, WA 98321

## Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

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***Amended by IDR***

This report is the result of an Extended Focused Fundamental Recertification Survey at Rainier School, Program Area Team E, on 01/27/20, 01/28/20, 01/29/20, 01/30/20, 01/31/20, 02/04/20, 02/05/20, 02/06/20 and 02/07/20. A Sample of six Clients were selected from a census of 87 Clients, and eight Expanded Sample Clients were added. Failed facility practice was identified and citations written.

This survey was conducted by:

Arika Brasier
Linda Davis
Patrice Perry
Olivia St. Claire
Jim Tarr

## Governing Body

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:

Based on observation, record review, and interview, the facility's Governing Body failed to:

1. Ensure adequate staffing for one of six Sample Clients (Client #1) and four Expanded Sample Clients (Clients #7, Client #8, Client #10 and Client #14) when they went on an off-campus trip. This failure put Clients at risk for inadequate

## Laboratory Director's or Provider/Supplier Representative's Signature

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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.
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staff supervision if there was a need to get out of the vehicle.

Findings included ...

Record review of a Rainier School Off-Campus Trip slip, dated 01/29/20 and timed 9:00 AM, showed five Clients going on a scenic drive with three staff. The trip slip showed that Client #7 and Client #8 both required special supervision. Client #7 was PRO (defined as staff keeping him in their line of sight so staff would have to follow him if he left the group) when he was out of the house. Client #8 required one staff assigned to care for only him. The remaining staff was responsible for Client #1, Client #10, and Client #14, who was in a wheelchair.

Record review of a Rainier School Off-Campus Trip slip, dated 01/29/20 and timed 3:30 PM, showed seven Clients going to 5 Mile Drive with three staff. The trip slip showed that Client #7 and Client #15 required special supervision. Client #7 was PRO (defined as staff keeping him within their line of sight) when he was out of the house. The trip slip identified that the staff assigned to Client #7 was also responsible for the supervision of two other Clients. If the Clients needed to exit the vehicle, the staff assigned to Client #7 would have to ensure the safety of the two additional Clients as well as provide the PRO for Client #7.

Record review of the facility's Standard Operating Procedure (SOP) 3.17 titled, "Off-Campus Leisure Trips," issued 03/31/19, showed that when Clients had greater supervision needs, the fewer number of Clients should go on the trip.
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The SOP did not provide guidelines for staff to determine how many staff needed to go based on the needs of the Clients attending the trip.

During an interview on 02/05/20 at 10:42 AM, Staff F, Attendant Counselor Manager, when asked how staff would assist Clients to the bathroom, stated that staff assigned to a Client with special supervision would have to take responsibility of the other Clients, including their own assigned Client.

2. Have a policy or procedure that directed investigators to identify abuse, neglect, and mistreatment in their investigatory process and determine if those actions had occurred. This resulted in one of ten incidents (#9005) not having a finding of neglect when staff failed to follow the supervision needs of one Expanded Sample Client (Client #13) and he left the facility without staff's knowledge. This failure resulted in all Clients being at risk for abuse, neglect, and mistreatment.

Findings included ...

Record review of Developmental Disabilities Administration (DDA) policy 12.02, 06/2017, titled, "RHC Incident Investigations," showed all Category I incidents must be referred to DDA's State Investigations Unit (SIU) for investigation. Category I incidents included all allegations of suspected abuse, neglect, financial exploitation, abandonment, or mistreatment of a child or vulnerable adult.

Record review of Developmental Disabilities Administration (DDA) policy 12.02, 06/2017, titled, "RHC Incident Investigations," showed all Category I incidents must be referred to DDA's State Investigations Unit (SIU) for investigation. Category I incidents included all allegations of suspected abuse, neglect, financial exploitation, abandonment, or mistreatment of a child or vulnerable adult.

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Administration (DDA) policy 12.02 titled, "RHC Incident Investigations," showed the following:

- SIU investigations must "Identify policies, procedures, and standard operating procedures, etc., that may be applicable to the incident or allegation". The policy did not direct SIU investigators to determine if abuse, neglect, or mistreatment had occurred.

- It did not direct SIU investigators to resolve discrepancies or information discovered during the investigations, and they were not directed to make recommendations to safeguard Clients before or after the completion of the report.

During an interview on 01/31/20 at 11:20 AM, Staff A, Superintendent, stated that SIU conducted all allegations of abuse, neglect, and mistreatment. Staff A stated SIU followed DDA policy 12.02.

The facility's current policies (12.02 RHC Incident Management, 5.06 Clients' Rights, 5.13 Protection from Abuse: Mandatory Reporting, and 2.25 Incident Management) related to investigations of allegations of abuse, neglect, and mistreatment failed to direct investigators to:

- Determine if abuse, neglect, or mistreatment did or did not occur
- Resolve all discrepancies of information
- Provide recommendations for safeguarding Clients
- Protect Clients right
- Ensure Clients received all required programs and services
- Ensure appropriate corrective action was taken
### Summary Statement of Deficiencies

**Event ID:** Facility ID: WA40110

**If continuation sheet Page 5 of 6**

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Record review and interview showed that the facility failed to identify neglect for one Expanded Sample Client (Client #13) when staff did not follow his supervision needs and he left the facility without staff being aware. See W127 for details.

Record review and interview showed that the facility failed to ensure their investigatory process identified abuse, neglect, and mistreatment and directed investigators to make recommendations for safeguarding Clients. See W149 for details.

3. Provide evidence that three out of ten background check results for current employees (Staff X, Staff CC, and Staff DD) were available to verify the staff were eligible to work with vulnerable adults. This failure left all Clients at risk for having care provided by staff who were not eligible to care for vulnerable adults.

Findings included ...

Record review on 02/07/20 of ten current staff members' background check results showed Staff CC and Staff DD did not have their results filed at the facility. The background check provided by the facility for Staff X had a misspelled last name, also resulting in no valid background check.

During an interview on 02/10/20 at 10:14 AM, Staff N, Administrative Assistant 4, stated that the facility was unable to find the two missing background results and was waiting to hear back from the off-site Background Check Central Unit regarding Staff X.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 50G046 |

**NAME OF PROVIDER OR SUPPLIER**

RAINIER SCHOOL PAT E

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

320 RYAN ROAD
BUCKLEY, WA 98321

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4. Develop a process to guide staff and ensure one Expanded Sample Client's (Client #10) personal refrigerator stayed cleaned and defrosted, and ensure his food was stored properly and thrown out when needed. Due to this failure, Client #10 was at risk for food borne illness, and left staff unaware of how to ensure his refrigerator would be cleaned and defrosted.

Findings included ...

Observation on 01/30/20 at 5:54 PM at Hyak House showed Client #10 ate his dinner, which included a pork chop. Pork chops were not on the menu for dinner. Staff O stated that Client #10's mother brought him food from home.

Observation on 01/31/20 at 7:35 AM at Hyak House showed Direct Care Staff (DCS) asked Client #10 if he had milk in his refrigerator, and then stated, "Go get the milk from the fridge in your room." At 7:38 AM Client #10 returned to the kitchen with a container of almond milk.

Observation on 02/06/20 at 9:46 AM at Hyak House showed Room Client #10's bedroom, had a small size refrigerator (approximately half the size of an average kitchen refrigerator) with a separate door for the freezer. The freezer contained a large amount of frost surrounding all sides of the freezer, decreasing the capacity by at least 25%. A DCS was in the room at the time of the observation. When asked if DCS had instructions to assist the Client with cleaning old food from the refrigerator, wiping out the refrigerator, and/or defrosting the appliance, DCS stated they did not.
### W 104

Continued From page 6

Record review of the Rainier School Monthly Refrigerator, Freezer and Lock Box Cleaning Schedule, provided by Staff N, Administrative Assistant 4, showed that staff would clean refrigerators monthly and defrost freezers on the living units. The schedule did not identify if a Client's personal refrigerator would be cleaned/defrosted by staff or the Client. Staff N's note attached to the schedule showed the facility did not have a SOP to direct staff on maintaining the appliance when it was the personal property of a Client.

During an interview on 02/06/20 at 9:41 AM, Staff F, ACM, stated that if DCS saw Client #10's mom bring in food they would put a date on the food.

5. Ensure their policy for tuberculosis (TB) testing provided an alternate method of testing for one of six Sample Clients (Client #3), within three days of admission. This failure prevented the facility from identifying if Client #3 had TB.

Findings included ...

Record review of Client #3's Admission Healthcare Assessment, dated 01/07/20, showed Client #3 was admitted to the facility on [date] and his mother requested general anesthesia (sedation to the point of unconsciousness) for any procedure that involved needles.

Record review of the facility's SOP 4.20 titled, "Tuberculosis," issued 04/30/19, showed all newly admitted Clients would receive a TB test within three days of admission. The SOP described the TB test as a small amount of
W 104  Continued From page 7
serum injected under the skin of the arm. The SOP did not indicate what would occur if staff could not complete the TB test as the policy instructed.

During an interview on 02/06/20 at 8:55 AM, Staff L, Infection Control Nurse, stated that staff did a symptom review for TB for Client #3 due to his inability to tolerate needles.

Record review of Client #3’s TB health questionnaire, provided by Staff L on 02/06/20, showed completion on 2/20, 26 days after Client #3’s admission to the facility.

W 125  PROTECTION OF CLIENTS RIGHTS
CFR(s): 483.420(a)(3)

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 observation, record review, and interview, the facility failed to ensure one Expanded Sample Client (Client #7) had a plan to reduce the restriction of his locked closet. This failure prevented the Client from having free access to his personal belongings.

Findings included ...

Observation at Hyak House on 02/05/20 at 9:29 AM showed Client #7 took off his socks and went to his room. Direct Care Staff went to Client #7’s bedroom with him and unlocked his closet and drawers so Client #7 could get a clean pair of
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G046

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ________________________
B. WING ___________________________

(X3) DATE SURVEY COMPLETED ________
C. 02/07/2020

NAME OF PROVIDER OR SUPPLIER
RAINIER SCHOOL PAT E

STREET ADDRESS, CITY, STATE, ZIP CODE
320 RYAN ROAD
BUCKLEY, WA 98321

(X4) ID PREFIX TAG

(X5) 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)

COMPLETION DATE

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socks.

Record review of Client #7's Annual Psychological Evaluation and Comprehensive Functional Analysis, dated 12/04/19, showed a locked closet due to him pooping and peeing in his room and soiling his belongings. The reduction plan for the locked closet showed when he had not had any instances of pooping in inappropriate places for six consecutive months; the facility would meet to discontinue the restriction of locking his closet. There was no training plan for how Client #7 would learn to discontinue the inappropriate behavior in order to gain free access to his belongings.

During an interview on 02/05/20 at 10:25 AM, when asked how Client #7 would learn not to pee and poop in inappropriate places, Staff H, Psychology Associate, stated that Client #7 needed to increase his vocabulary to express himself. When asked if Client #7 could make the connection between talking with staff and his inappropriate peeing/pooping, she stated "probably not."

W 127 PROTECTION OF CLIENTS RIGHTS

CFR(s): 483.420(a)(5)

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to protect one of six Sample Clients (Client #3) when they were made aware of an
allegation of sexual abuse, and one Expanded Sample Client (Client #13) when he left the house without staff's knowledge and then left the facility grounds. This failure left Client #3 at risk for ongoing abuse when Direct Care Staff did not have a plan to follow if the Alleged Perpetrator (AP), a family member, visited Client #3, and left Client #13 at risk for significant harm, up to and including death.

Findings included ...

Client #3
Review of Client #3's file showed a facility admission date of 1/20.

Review of Client #3's file showed a typed letter, dated 12/17/19, from Client #3's mother. The letter showed that she planned to file a legal protection order against a family member, the AP, prior to Client #3's admission to the facility to prevent the AP from seeing Client #3 after admission to the facility.

Record review of Client #3's Healthcare Assessment, dated 01/07/20, showed that the facility physician knew that Client #3's mother had identified concerns about Client #3's safety around the AP, a family member. The mother had concerns of inappropriate sexual behavior.

Record review of Client #3's Psychiatric Consultation, dated 01/09/20, showed "During the intake mother (sic) noted that [AP] cannot see him as she was afraid that he was sexually abusing him [Client #3] when he was giving him [Client #3] showers ..."
## REVIEW OF CLIENT #3'S FILE

Review of Client #3's file showed no instructions for staff to follow to protect Client #3 from sexual abuse if the AP visited.

During an interview on 01/28/20 at 9:26 AM, Staff J, Qualified Intellectual Disability Professional, stated that there was not a plan to protect the Client from the AP and there were no instructions for staff to follow if the AP attempted to visit Client #3.

During an interview on 01/28/20 at 1:40 PM, Staff S, Program Area Team Director, stated that the facility was aware of the allegation of sexual abuse prior to Client #3's admission to the facility.

During an interview on 02/05/20 at 1:30 PM, Staff A, Superintendent, stated that there was no specific protection plan in place for Client #3.

**Client #13**

Record review of Client #13's Positive Behavior Support Plan, dated 12/22/19, showed that he had a challenging behavior of trying to get away from people. Staff were instructed to remain about four to six feet from him when he left the house and carry a radio.

Record review of the facility's 5-Day Investigation #9005, dated 01/24/20, showed that Client #13 left his house without staff being aware. An off duty staff returning from his lunch break discovered him walking down Collins Road, approximately 0.8 miles from the facility, without a coat.

Record review of Weather History from the following website:

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**W 127**

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During an interview on 01/28/20 at 1:40 PM, Staff S, Program Area Team Director, stated that the facility was aware of the allegation of sexual abuse prior to Client #3's admission to the facility.

During an interview on 02/05/20 at 1:30 PM, Staff A, Superintendent, stated that there was no specific protection plan in place for Client #3.

**Client #13**

Record review of Client #13's Positive Behavior Support Plan, dated 12/22/19, showed that he had a challenging behavior of trying to get away from people. Staff were instructed to remain about four to six feet from him when he left the house and carry a radio.

Record review of the facility's 5-Day Investigation #9005, dated 01/24/20, showed that Client #13 left his house without staff being aware. An off duty staff returning from his lunch break discovered him walking down Collins Road, approximately 0.8 miles from the facility, without a coat.

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<td><a href="https://www.wunderground.com/history/daily/us/wa/buckley/KSEA/date/2020-1-22">https://www.wunderground.com/history/daily/us/wa/buckley/KSEA/date/2020-1-22</a>, showed that on the date and time of the incident the temperature was approximately 45 degrees and it was raining.</td>
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Record review of an Individual Habilitation Plan Revision, dated 01/22/20, showed that Client #13's guardian stated that Client #13 leaving the facility grounds was an issue and that while Client #13 lived in the community he had been found on airplanes, trains, ferries, and had walked long distances before being found.

Record review of the facility's 5-Day Investigation Report #9005, dated 01/24/20, showed that the staff assigned to Client #13 was assisting a video communications person who was doing a placement video for another Client and was not aware Client #13 had left the House. The investigation concluded that the potential for a negative outcome appeared high for Client #13 as the road lacked sidewalks. The facility did not conclude neglect had occurred when it failed to provide the supervision services necessary to meet Client #13's needs.

Record review of "Definitions" 42 Code of Federal Regulations (CFR) 483.5 showed that neglect was defined as the failure of the facility, it's employees, or service care providers to provide goods and services that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

Record review of Developmental Disabilities Administration (DDA) policy 12.02 titled, "RHC Incident Investigations," showed all Category I incidents must be referred to DDA's State...
**NAME OF PROVIDER OR SUPPLIER**
RAINIER SCHOOL PAT E

**STREET ADDRESS, CITY, STATE, ZIP CODE**
320 RYAN ROAD
BUCKLEY, WA 98321

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<td>W 127</td>
<td>Continued From page 12 Investigation Unit (SIU) for the investigation. Category I incidents included all allegations of suspected abuse, neglect, financial exploitation, abandonment, or mistreatment of a child or vulnerable adult. The policy did not direct SIU investigators to determine if abuse, neglect, or mistreatment had occurred. During an interview on 01/31/20 at 11:20 AM, Staff A, Superintendent, stated that SIU conducted investigations into all allegations of abuse, neglect, and mistreatment. She stated that the current policy SIU used was 12.02 RHC Incident Management. When asked if the policy directed SIU to make a determination of abuse, neglect, or mistreatment, Staff A, stated “No”.</td>
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**PROTECTION OF CLIENTS RIGHTS**

CFR(s): 483.420(a)(6)

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to appropriately address signs and symptoms of constipation (a known trigger for agitation) for one of six Sample Clients (Client #1). Client #1 had a well-documented history of agitation when he was constipated and staff were to intervene early, to prevent his behaviors from escalating. The Client had objective, diagnostic testing that showed he was constipated and the facility...
increased his psychotropic meds, against the recommendation of his ... This failure resulted in Client #1 receiving unnecessary antipsychotic medications.

Findings included ...

Observation on 01/29/20 at 2:02 PM at Hyak House showed Client #1 sat at the dining room table with his eyes closed. He ate his snack with his eyes closed.

Observation on 01/30/20 at 12:25 PM at Hyak House showed Client #1 sat on a couch in the TV room, eyes closed. At 12:36 PM, Client #1 sat on a couch in the TV room, eyes closed. A Direct Care Staff (DCS) sat next to him talking to him.

Client #1 did not respond and DCS stated, "You are tired today."

Observation on 01/30/20 at 12:58 PM at Pine Hall showed Client #1 sat on a couch in room #130, eyes closed. At 1:09 PM Client #1 opened his eyes and briefly spoke with a staff member. At 1:11 PM, he closed his eyes until he left Pine Hall at 1:14 PM.

Observation on 01/30/20 at 1:28 PM at Hyak House showed Client #1 sat on a couch in the TV room, eyes closed. Client #1 briefly left the TV room, re-entered at 1:31 PM, and sat on the same couch, eyes closed.

Observation on 01/30/20 at 2:11 PM at Hyak House showed Client #1 sat on a couch in the TV room, eyes closed.

Observation on 01/31/20 at 7:17 AM at Hyak
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House showed Client #1 sat on a couch in the TV room, eyes closed. At 7:22 AM, a DCS asked Client #1 if he was watching the news. Client #1 did not respond, and his eyes remained closed. At 7:41 AM, a DCS questioned another DCS if they noticed that Client #1 was walking around with his eyes closed. From 7:53 AM to 7:58 AM, Client #1 sat on a couch with his eyes closed. At 8:10 AM, Client #1 was still on the couch with his eyes closed. At 8:31 AM, Client #1 sat on the couch, eyes closed. At 8:41 AM, a DCS sat on the couch next to Client #1 and asked him multiple questions. Client #1 did not respond and he remained on the couch, eyes closed.

Record review of Client #1's Annual Psychological Evaluation and Comprehensive Functional Analysis, dated 12/09/19, showed he appeared sedated and his dose of chlorpromazine (an antipsychotic medication commonly used to treat hallucinations and delusions) was being slowly reduced.

Record review of Client #1’s Psychology Review, dated 12/04/19, for the month of November 2019 showed "his aggression is still up and his disruption is way up." The review also identified that Client #1 had some physical pain or discomfort, as he appeared to be grunting while in the bathroom and it did not always result in a bowel movement. The Psychology Associate indicated that Client #3 appeared to be in physical discomfort.

Record review of Client #1's Positive Behavior Support Plan, dated 12/18/19, showed he may become agitated when constipated. Staff were to assess for constipation early due to a very strong
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<td>history of getting upset when constipated and the sooner it could be resolved, the fewer challenging behaviors Client #1 exhibited.</td>
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<td>Record review of Client #1's Psychology Review, dated 01/08/20, for the month of December 2019, showed &quot;SIB [self-injurious behavior] was severe enough to warrant padding his headboard and footboard as well as the walls around his bed.&quot; and &quot;became self-injurious again as well as throwing chairs ...&quot;</td>
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<td>Record review of Client #1's Psychiatric Assessment, dated 12/05/19, showed the Client had a history of similar behaviors when constipated. The consulting psychiatrist recommended an x-ray to rule out constipation, laxatives until the constipation was relieved and on-going behavior monitoring. If Client #1 continued to be agitated after the constipation was resolved, his chlorpromazine would increase by adding a 100mg dose at noon.</td>
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<td>Record review of Client #1's file showed:</td>
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<td>- On 12/05/20, an x-ray showed fecal loading (a large amount of poop, may also be an impaction) in the colon. Client #1's medications to treat constipation were changed.</td>
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<td>- On 12/11/19, Client #1 hit his head on a wall, had a bump on his head, and a red mark on his forehead. Client #1 threw himself off his bed, onto the floor, and banged his head on the wall. Client #1 had an eye exam related to multiple Self Injurious Behaviors (SIB) from hitting his head on the wall and floor. Client #1 went to the Emergency Room for evaluation of a potential head injury.</td>
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<td>- On 12/11/19, a facility physician increased</td>
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### Name of Provider or Supplier

**RAINIER SCHOOL PAT E**

**Address:** 320 RYAN ROAD, BUCKLEY, WA 98321

### Provider's Plan of Correction

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</table>
| W 128 | Continued From page 16 | | Client #1's chlorpromazine (an antipsychotic medication commonly used to treat hallucinations and delusions).  
- On 12/12/19, an x-ray showed fecal loading with possible constipation and an additional laxative was ordered, as a one-time treatment, for the constipation.  
Record review of Client #1's Quarterly Drug Regimen Review, dated 12/18/19, showed that psychiatry added an additional 100mg of chlorpromazine because "constipation was ruled out."  
During an interview on 02/05/20 at 11:00 AM, Staff H, Psychology Associate, stated that the physicians made the decision to increase his psych meds.  
During an interview on 02/05/20 at 3:29 PM, Staff G, Qualified Intellectual Disability Professional, stated that the physician determined Client #1 was not constipated, so they increased his psych meds.  
Record review of Client #1's Interdisciplinary Progress Notes showed:  
- On 12/18/19, Client #1 hit himself repeatedly in the face and side of his head.  
- On 12/18/19, Client #1 pulled a cabinet over in his room, threw himself on the floor, slapped his face, and rolled around on the floor. Client #1 injured his finger during the SIB, and had bruising on his face.  
- On 12/18/19, an x-ray showed a moderate amount of rectal stool. | |
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 50G046  
**State:**  
**Provider/Supplier Name:** RAINIER SCHOOL PAT E  
**Street Address:** 320 RYAN ROAD  
**City, State, Zip Code:** BUCKLEY, WA 98321  
**Printed:** 11/13/2020

**Date Survey Completed:** 02/07/2020

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| W 128 | Continued From page 17  
During an interview on 02/06/20 at 10:14 AM, Staff M, Physician, stated that the Client's intestinal issues looked managed because the Client was "treated for constipation and his medications were tweaked." | W 128 |  
| W 137 | PROTECTION OF CLIENTS RIGHTS  
CFR(s): 483.420(a)(12)  
The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.  
This STANDARD is not met as evidenced by:  
Based on record review and interview, the facility failed to safeguard the personal property of one Expanded Sample Client (Client #12) when staff did not document it on Client #12's Personal Property Record. This failure prevented the facility from identifying that Client #12's bicycle was stolen and left other Client's belongings unaccounted for.  
Findings included ...  
Record review of the facility's Standard Operating Procedure 3.14 titled, "Client Personal Property," issued 01/27/20, showed, "All new items purchased must be entered onto the client's Personal Property Record upon return to Rainier School. This process must be completed within twenty-four (24) hours of the first business day that the item was purchased and received by a Rainier School employee and/or client."  
Record review of the facility's Incident Report #8900, dated 11/15/19, showed Client #12's | W 137 |  
| W 128 |  |  |  |
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**
RAINIER SCHOOL PAT E

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
320 RYAN ROAD
BUCKLEY, WA 98321

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| W 137          | Continued From page 18
|                | three-wheeled pedal bike was stolen from the facility grounds on 11/09/19. The facility's investigation determined the bike was received by the facility on 06/29/19. An Attendant Counselor had signed for the bike but had not entered it into Client #12's Personal Property Record. During an interview on 02/04/20 at 1:41 PM, Staff D, Investigator 2, stated that the bike should have been on the inventory sheet. | W 137          | W 138 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) | W 138          |
|                | The facility must ensure the rights of all clients. Therefore, the facility must ensure that each client is dressed in his or her own clothing each day. This STANDARD is not met as evidenced by: Based on observation record review, and interview, the facility failed to ensure one of six Sample Clients (Client #1) and two Expanded Sample Clients (Client #7 and #8) wore their own socks when house staff did not mark their personal belonging with their names. This failure resulted in Clients using stock items, and not their own clothing. Findings included...
|                | Observation at Hyak House on 01/30/20 at 7:23 PM showed Client #1 wore white crew socks with the initials "HY" in black marker across the toe of the socks. Direct Care Staff verified the initials stood for the house (Hyak) and Client #1's initials were not on the socks. | W 138          | W 138 | W 138 |
## SUMMARY STATEMENT OF DEFICIENCIES

### Observation
- **Observation**: At Hyak House on 01/30/20 at 7:40 PM, Client #7 and Client #8 wore white crew socks with the initials "HY" in black marker across the toe of the socks.
- **Observation**: At Hyak House on 01/31/20 at 7:12 AM, Client #1 wore white crew socks with the initials "HY" in black marker across the toe of the socks.
- **Observation**: At Hyak House on 01/31/20 at 8:12 AM, Client #7 wore white crew socks with the initials "HY" in black marker across the toe of the socks.

### Record Review
- **Record Review**: Facility Standard Operating Procedure 3.14, titled "Client Personal Property," issued 01/27/20, showed items would be marked with the Client's name and living unit within 24 hours of receipt.

### Interview
- **Interview**: On 02/05/20 at 9:13 AM, Staff F, Attendant Counselor Manager, stated that the Clients received the socks from the facility commissary and staff should have labeled them with the Client's name.

### Staff Treatment of Clients

#### CFR(s): 483.420(d)(1)
- The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

#### This STANDARD is not met as evidenced by:
- Based on record review and interview, the facility's policies and procedures were not
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| W 149  | Continued From page 20 implemented for the prevention and correction of neglect of one Expanded Sample Client (Client #13). The facility did not identify neglect, nor take appropriate corrective action to safeguard Client #13, when staff actions met the definition of neglect as defined in "Definitions" 42 Code of Federal Regulations (CFR) 483.5. This failure prevented the facility from ensuring Clients were safe. Findings included ...

Record review of "Definitions" 42 Code of Federal Regulations (CFR) 483.5 showed that neglect was defined as, "The failure of the facility, its employees, or service care providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

Record review of Developmental Disabilities Administration (DDA) policy 12.02 titled, "RHC Incident Investigations," dated 06/2017, showed all Category I incidents must be referred to DDA's State Investigation Unit (SIU) for investigation. Category I incidents included all allegations of suspected abuse, neglect, financial exploitation, abandonment, or mistreatment of a child or vulnerable adult. The policy did not direct SIU investigators to determine if abuse, neglect, or mistreatment had occurred.

Record review of DDA Policy 12.01 titled, "Incident Reporting and Management For DDA Employees," dated 10/2019, showed one of the purposes of the policy was, "The intent of the DDA incident reporting and management system is to identify, analyze and correct hazards, risks..."
or potentially harmful situations from occurring and prevent a future recurrence as much as possible." It also showed that a Client without good survival skills could be in immediate jeopardy when missing for any amount of time. The facility must document whether actions were implemented and successful to protect the Client's health and welfare along with follow-up contact with the Client and/or their legal guardian to ensure they are aware of and satisfied with the follow-up actions taken.

Record review of DDA Policy 5.13 titled, "Protection From Abuse: Mandatory Reporting," dated 08/2015, showed the purpose of this policy was to describe the process used to protect the health, safety, and well-being of Clients, and to ensure that Client abandonment, abuse, personal and financial exploitation, neglect and self-neglect were reported, investigated, and resolved. This policy showed that DDA would process allegations in a manner that ensured prompt investigation and resolution. The definition of neglect included, "an act or omission that demonstrated a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. Including but not limited to: .....Failure to supervise which results in a client wandering, missing or running away."

Record review of DDA Policy 2.25 titled, "Incident Management," dated 07/02/19, showed its purpose was to, "define both the processes by which events and incidents described, reported, investigated, and how Corrective Action Plans (CAPs) are created and monitored. It showed
Continued From page 22

neglect classified as a Category I incident, yet classified a Client that left the facility grounds without needed supports or supervision as a Category II incident. The Program Area Team (PAT) Director was to develop a plan of correction. This policy did not contain in the process to communicate with guardians and family any notification to the Client and/or legal guardian regarding the follow-up actions taken to ensure they were satisfied with the plan as required in Policy 12.01 described above.

Record review of Client #13's Positive Behavior Support Plan (PBSP), dated 12/22/19, showed that he was on protective supervision off the house and staff were to be four to six feet from him when he left the house and carry a radio with them.

Record review of the facility's 5-Day Investigation #9005, dated 01/24/20, showed Client #13 left his house without staff being aware. An off duty staff returning from his lunch break discovered him walking down Collins Road, approximately 0.8 miles from the facility.

Record review of the facility's 5-Day Investigation Report #9005, dated 01/24/20, showed that the staff assigned to Client #13 was engaged in assisting another Staff with a video conference, and was not aware Client #13 had left the house. Therefore, staff did not follow the protective supervision guidelines outlined in Client #13's PBSP for when he left the house. They concluded that the potential for a negative outcome appeared high for Client #13, as the road lacked sidewalks. The facility did not
**SUMMARY STATEMENT OF DEFICIENCIES**

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Conclude neglect had occurred when it failed to provide the supervision services necessary to meet Client #13's needs and no corrective action was taken to ensure this would not happen again.

During an interview on 01/31/20 at 11:20 AM, Staff A, Superintendent, stated that SIU conducted investigations into all allegations of abuse, neglect, and mistreatment. She stated that the current policy SIU used was 12.02 RHC Incident Management. When asked if the policy directed SIU to make a determination of abuse, neglect, or mistreatment, Staff A, stated "no". When asked if the policy directed SIU to provide recommendations for safeguarding Clients before and after an allegation of abuse, neglect, or mistreatment Staff A, stated that it did not provide recommendations for ongoing safeguarding.

| W 152 | STAFF TREATMENT OF CLIENTS |
| CFR(s): 483.420(d)(1)(iii) |

The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure it had evidence of the completed staff background checks for three of ten staff (Staff X, Staff CC, and Staff DD) prior to them working with Clients. This failure resulted in staff working with Clients without having verification that they were eligible to work with...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat E  
**Address:** 320 Ryan Road, Buckley, WA 98321

#### Summary Statement of Deficiencies

1. **W 152** Continued From page 24  
   Vulnerable adults, leaving all Clients at risk for abuse, neglect, and mistreatment.

   Findings included...

   Record review of employee background checks showed the facility could not produce background checks for Staff CC and Staff DD. The background check produced for Staff Y did not have the correct spelling of her last name. The facility crossed out the misspelled name and wrote the correct spelling on the page. There was no evidence the facility ran the background check through the system with the correct spelling of her name.

   During an interview on 02/07/20 at 8:33 AM, Staff N, Administrative Assistant 4, stated the facility did not have the background check results for Staff CC, Staff DD, or Staff Y.

2. **W 154** Staff Treatment of Clients  
   **CFR(s): 483.420(d)(3)**

   The facility must have evidence that all alleged violations are thoroughly investigated.

   **This STANDARD is not met as evidenced by:**  
   Based on record review and interview, the facility failed to resolve discrepancies in one of ten facility investigations (#9005). This failure prevented the facility from understanding all aspects of the incident in order to develop corrective action for one Expanded Sample Client (Client #13).

   Findings included...

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**Additional Information:**

- **ID Prefix TAG:** W 152
- **Completion Date:** 02/07/2020
- **Provider's Plan of Correction:** Each corrective action should be cross-referenced to the appropriate deficiency.

---

This document was prepared by Residential Care Services for the Locator website.
Continued From page 25

Record review of the facility's 5-Day Investigation Report #9005, dated 01/24/20, showed:

1. Client #13 left facility grounds on 01/22/20, without his house staff's knowledge, and was found walking down Collins Rd, approximately 0.8 miles from the facility. He was discovered by an off duty staff returning to the facility from his lunch break.

2. Page 2 of the report contained a copy of an Interdisciplinary Progress Note, dated 01/22/20, entered by a Qualified Intellectual Disability Professional, showed "He is not PRO (protective supervision with staff being four to six feet from Client #13 and utilization of a radio) off the house."

3. Page 3 of the report contained a witness statement by Direct Care Staff, which showed "They recently made [Client #13's first name] (PRO) off house only".

4. Page 8 of the report contained a copy of Client #13's Positive Behavior Support Plan, dated 12/12/19, which showed Client #13 was on protective supervision off the house and that staff should stay within four to six feet of him.

The facility's report did not address the discrepancies regarding staff's knowledge of Client #13's supervision level.

During an interview on 02/04/20 at 1:41 PM, Staff D, Investigator 2, stated that the facility's 5-Day Investigation Report #9005 was the final report.
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<td>W 159</td>
<td>Continued From page 26 CFR(s): 483.430(a) 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 observation, record review, and interview, the Qualified Intellectual Disability Professional (QIDP) failed to provide oversight for the integration, coordination, and monitoring of three of six Sample Clients' (Client #1, Client #4, and Client #5) and two Expanded Sample Clients' (Client #7 and Client #11) Individual Habilitation Plans (IHP). This failure resulted in inaccurate IHPs, lack of active treatment, violation of Client #7’s right to access his personal possessions, and Client #4 had the potential of receiving the incorrect diet. Findings included ... Client #4 Record review of Client #4's IHP dated 09/24/19 showed that on page one his diet was a &quot;2200 calorie, chopped diet. He also receives a diabetic diet and three snacks daily, whole grains only.&quot; On page seven of the IHP, Client #7’s diet was stated as a 2200 CH (chopped), GR (ground) MT (meat), Diabetic with 3 snacks; fruit 2x/day as snacks; whole grain only. Hs (house) to soften hard foods such as hard veggies. During an interview on 02/04/20 at 10:42 AM, Staff Q, Qualified Intellectual Disability Professional stated that the diet described on page 1 of Client #4’s IHP was incorrect.</td>
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Record review and interview showed the facility failed to provide Active Treatment services to one of six Sample Clients (Client #1) and one Expanded Sample Client (Client #11). See W195 for details.

Record review and interview showed the facility admitted one Expanded Sample (Client #11) for the purpose of providing a short-term place to live while his community living setting hired and trained staff to care for Client #11. There was never an intent to admit Client #11 for active treatment services at the facility. See W198 for details.

Observation, record review, and interview showed the facility failed to develop an Individual Habilitation Plan that addressed one of six Sample Client's (Client #1) identified needs. See W206 for details.

Observation, record review, and interview showed the facility failed to ensure one Expanded Sample Client (Client #7) had a plan to reduce the restriction of a locked closet. See W214 for details.

Record review and interview showed the facility failed to ensure one of six Sample Clients (Client #1) had a communication assessment that identified and addressed his communication needs. See W220 for details.

Record review and interview showed the facility failed to develop an Individual Habilitation Plan for one Expanded Sample Client (Client #11) within 30 days of his admission. See W226 for details.
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<td>W 186</td>
<td>DIRECT CARE STAFF</td>
<td>CFR(s): 483.430(d)(1-2)</td>
<td>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 unit.</td>
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This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were enough Direct Care Staff (DCS) assigned to Chelan House to meet the supervision needs of one Expanded Sample Client (Client #13). This failure resulted in Client #13 being discovered 0.8 miles away from the facility, in heavy rains, without a coat, by an off duty staff.

Findings included ...

Record review of Rainier School Duty Office
Basic Care Levels sheet, revised 01/22/20, showed Chelan House's minimum care level for staffing was seven on the AM shift.

Record review of a Rainier School Staff Communication Sheet for Chelan House, dated 01/22/20, showed the facility deployed five DCS to the House on the day shift.

Record review of the Client Listing for Chelan House on 01/22/20 showed there were six Clients living at the House.

Record review of the Rainier School Staff Communication Sheet for Chelan House, dated 01/22/20, showed for AM shift, three DCS were assigned 1:1 supervision (dedicated to the care of that Client only) for one Client each. One DCS was assigned two Clients, one of which had protective supervision if he left the house. If the Client with protective supervision left the house, the would be faced with not being able to carry out his assignment of providing supervision of both Clients. Another DCS was assigned one Client who was on protective supervision if he left the house.

Record review of the facility's 5-Day Investigation Report #9005, dated 01/24/20, showed that on 01/22/20 Client #13 was discovered at 12:57 PM by an off duty staff, walking down Collins Rd approximately 0.8 miles away from the facility. It showed the following staffing at the time of the incident:

One staff on break.
One staff covering a 1:1 Client for the staff on break.
One staff assigned to a 1:1 Client. One staff assigned to three Clients. Two of the Clients had protective supervision if they left the house (including Client #13). The third Client required protective supervision if he showed signs of agitation. During the time in which Client #13 left the house this staff was participating in a video conference related to the care of one of the three Clients under her care. One staff assigned a 1:1 Client.

The investigation concluded that staff were working with other Clients and were not aware Client #13 had left the House so they did not follow his protective supervision guidelines outlined in his PBSP. The investigation concluded that the potential for a negative outcome appeared high for Client #13 as the road lacked sidewalks.

Record review of a Duty Office staffing sheet, dated 01/22/20, showed the names of five DCS assigned to Chelan on the AM shift.

During an interview on 02/05/20 at:35 PM, Staff V, Residential Services Coordinator, stated that the Duty Office staffing sheet, dated 01/22/20, was accurate and that those were the staff working the AM shift on that day.

The facility must ensure that specific active treatment services requirements are met.

This CONDITION is not met as evidenced by:
**Rainier School Pat E**

**320 Ryan Road**
**Buckley, WA 98321**

**W 195 Continued From page 31**

Based on record review and interview, the facility failed to provide Active Treatment services to one of six Sample Clients (Client #1) and one Expanded Sample Client (Client #11). This failure prevented Client #1 from benefitting from specialized training to help him be more independent and allow him to live in a less restrictive environment. Client #11 did not have an Individual Habilitation Plan developed and as a result, he did not receive active treatment training.

Findings included...

Record review and interview showed the facility admitted one Expanded Sample Client (Client #11) for the expressed purpose of allowing a community provider time to hire and train staff. See W198 for details.

Observation, record review, and interview showed the facility failed to develop an Individual Habilitation Plan that addressed one of six Sample Client's (Client #1) identified needs. See W206 for details.

Record review and interview showed the facility failed to develop an Individual Habilitation Plan for one Expanded Sample Client (Client #11). See W226 for details.

Clients who are admitted by the facility must be in need of and receiving active treatment services.

**W 198 ADMISSIONS, TRANSFERS, DISCHARGE**

**CFR(s): 483.440(b)(1)**

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This document was prepared by Residential Care Services for the Locator website.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility admitted Expanded Sample Client #11 for the expressed purpose of providing a temporary place to live. The community living setting, which had accepted him for placement prior to being admitted to the Residential Habilitation Center (RHC), needed time to hire and train staff to care for Client #11. This failure resulted in Client #11 being admitted for purposes other than the need to receive active treatment services.

Findings included ...

Record review showed Client #11 was placed at the RHC on 2/20.

Record review of Client #11's Respite (short-term) Application, undated, showed Client #11 needed a place to stay after 1/19. The Respite Application requested short-term placement at a RHC.

Record review of the Code of Federal Regulations 483.440(b)(1), dated 04/13/18, showed "All client admissions must be based upon assessed developmental deficits which are prohibiting the client from living in a more independent setting and which require those intensive specialized supports, services, and supervision that only an ICF/IID can provide."

Review of Client #11's file showed no Individual Habilitation Plan (IHP).

Record review of Client #11's RHC document titled IHP Revision, dated 01/02/20 (documentation of a phone conference prior to...
Continued From page 33

Review of Client #11’s file at the RHC showed a Functional Behavior Assessment dated 03/25/19, completed prior to coming to the RHC. There was no updated facility behavioral assessment or training plan related to inappropriate behaviors. The file did not contain any skill training programs, program implementation instructions, documentation of programs, or monitoring of programs.

Record review of Client #11’s IHP Revision, dated 01/30/20, stated, "[Client #11’s first name] situation is unique in the since (sic) that before he was admitted to Rainier School, he had community placement vendor "[supported living name]", identified as wanting to provide [Client #11’s first name] with community placement. Due to being a new private agency, they were in need of hiring and training new staff before [Client #11 first name] arrival. Since [Client #11’s first name] is scheduled to move to "[supported living name]" on the IDT had to continue the process of scheduling his 30-day IHP." The IHP revision also stated, "The primary reason for this meeting was to share with his new staff..."
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat E  
**Street Address, City, State, Zip Code:** 320 Ryan Road, Buckley, WA 98321  
**Provider's Plan of Correction**

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**Recommendations that would be beneficial for [Client #11's first name] needs.**

During an interview on 02/06/20 at 8:43 AM, Staff AA, Placement Coordinator, stated that Client #11 did not qualify for services at his prior residence and "We housed him until they could take him," referring to the community provider.

During an interview on 02/06/20 at 9:30 AM, Staff W, Psychology Associate, stated that the facility admitted Client #11 for respite care. Staff W stated that the community provider that agreed to admit him into their services needed some time to train their staff.

During an interview on 02/07/20 at 9:31 AM, Staff BB, Attendant Counselor Manager, stated that staff did not implement any formal training programs for Client #11, as the facility did not complete his IHP. When asked if the facility admitted the Client to receive active treatment, Staff BB stated the Client was at the facility for respite care only.

**Individual Program Plan**

**CFR(s): 483.440(c)(1)**

Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.
### SUMMARY STATEMENT OF DEFICIENCIES

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This STANDARD is not met as evidenced by:

- Based on observation, record review, and interview, the facility failed to develop an Individual Habilitation Plan (IHP) that addressed one of six Sample Client's (Client #1) identified needs. This failure resulted in Client #1 not receiving a program of specialized training to help him learn to be more independent, and prolonged his time at the facility.

Findings included ...

- Record review of Client #1's Comprehensive Functional Assessment of Day Training Programs, dated 11/08/19, showed Client #1 was dependent on staff to cue him. Client #1 was able to participate in training and would do so, as long as staff provided cues.

- Record review of Client #1's teaching plans showed no training related to his dependence for staff cues to complete tasks.

- Record review of Client #1's IHP, dated 12/18/19, showed:
  - The facility identified a long-term goal of increasing consistent completion of activities of daily living, including hygiene/grooming and domestic tasks. Client #1 had training programs to sweep the kitchen floor, take clean laundry from the washer and place it in the dryer, make a snack once a day, and to pay for an item.
  - One focus of the IHP was to manage his challenging behaviors by learning to relax. It showed that Client #1 had a routine of leisure "for quite some time."
  - Staff were to attempt to communicate with him when he showed signs of being overwhelmed, or...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
RAINIER SCHOOL PAT E

**STREET ADDRESS, CITY, STATE, ZIP CODE**
320 RYAN ROAD
BUCKLEY, WA 98321

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
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<tr>
<td></td>
<td></td>
<td>W 206 Continued From page 36 over stimulated. There were no training plans for communication.</td>
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<td>- The IHP identified that Client #1's engagement in active treatment was not a strong point. There were no training plans to help Client #1 engage in training.</td>
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<td>- Client #1 preferred to relax on his bed or in the living area of the house.</td>
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<td>- Client #1 was independent with toileting, showering, dental hygiene, eating, and dressing himself, and occasionally required a verbal cue to wear a coat. Client #1 had a current formal training plan for staff to cue him to take a shower. The program did not contain any training, the program instructions showed the Client showered himself, staff just told him to take a shower.</td>
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<td>Observation at Hyak House on 01/29/20 at 9:14 AM showed a Direct Care Staff (DCS) stated &quot;[Client #1 first name] come help with laundry.&quot; Client #1 stood up and went to the laundry room. The washing machine had not finished the cycle so Client #1 returned to the TV room.</td>
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<td>Observation at Hyak House on 01/30/20 at 1:29 PM showed a DCS stated, &quot;Help me get laundry out of washer?&quot; to Client #1. Client #1 went to the laundry room, removed towels from the washer and put them in the dryer after the DCS cued him. Client #1 left the laundry room after one minute.</td>
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<td>Observation at Hyak House on 01/30/20 at 6:25 PM showed Client #1 went into a bathroom with a DCS after being cued &quot;Come help me?&quot; as the DCS carried a bucket into the bathroom. Client #1 left the bathroom after less than 1 minute.</td>
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**DATE SURVEY COMPLETED**
02/07/2020

*This document was prepared by Residential Care Services for the Locator website.*
### SUMMARY STATEMENT OF DEFICIENCIES

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Observation at Hyak House on 01/31/20 at 8:25 AM showed a DCS stated, "Let's take laundry." Client #1 carried a basket to the laundry room. The DCS told the Client to empty the basket in the washing machine, and he did. Client #1 returned to the TV room one minute after entering the laundry room.

Observation at Hyak House on 01/31/20 at 8:32 AM showed a DCS cued Client #1 to get a push broom from the laundry room. Client #1 pushed the broom from the laundry room to his room, approximately 25 feet. The floor where the Client swept still had debris, Client #1 walked away and returned to the TV room. Staff did not attempt to have the Client finish the task.

The programs would only take moments to complete and did not provide the opportunity for learning additional independence as all of the programs included a verbal cue to complete the task, indicating the Client was able to do the task; he just needed a staff cue to complete it.

During an interview on 02/05/20 at 9:41 AM, Staff G, Qualified Intellectual Disability Professional (QIDP), stated that Client #1 was cue dependent on things he did not want to do and needed more motivation to complete tasks.

During an interview on 02/05/20 at 3:29 PM, Staff G, QIDP, stated the IHP, dated 12/18/19 was current. Staff G stated that Client #1 was "quick to learn" and they would add more training programs the closer Client #1 got to moving from the facility.
### Summary Statement of Deficiencies

(W 214 Continued From page 38)

**CFR(s): 483.440(c)(3)(iii)**

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 interview, the facility failed to ensure one Expanded Sample Client (Client #7) had a plan to reduce the restriction of a locked closet because he was peeing and pooping in his room, and soiling his belongings. This failure prevented him from learning appropriate ways to communicate and resulted in his closet remaining locked for years, denying him free access to his personal belongings.

Record review of Client #7's Annual Psychological Evaluation and Comprehensive Functional Analysis, dated 12/04/19, showed:

- Client #7 exhibited inappropriate pooping/peeing, including having a bowel movement or urinating in his bedroom. He would smear poop on walls, furniture, clothing and bedding, throw objects with poop on it, or go to staff with poop on his fingers. To decrease the number of incidents staff would remind Client #7 to use the bathroom every two hours.

- Client #7 would use his inappropriate behaviors to taunt staff when he was bored or sitting around, and would use the time to entertain himself by soiling his pants and then telling staff to clean it up.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat E  
**Street Address, City, State, Zip Code:** 320 Ryan Road, Buckley, WA 98321

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<tr>
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<th>Provider's Plan of Correction</th>
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<td>- Client #7 had a locked closet (and it had been locked most of his time at the school, admitted in 2000) due to his tendency to pee or poop in his room.</td>
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<td>- Client #7 could have his closet unlocked when he had no episodes of inappropriate defecation/urination for 6 months.</td>
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<td>- There were no training plans for the Client to learn that peeing or pooping in his room was inappropriate and if he discontinued the behavior, his closet would be unlocked.</td>
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<td>During an interview on 02/05/20 at 10:25 AM, Staff H, Psychology Associate, stated that Client #7 was learning to increase his vocabulary to express himself. When asked how learning vocabulary would teach him to not soil his pants, Staff H stated that staff would ask Client #7 why he soiled his pants and ask him what was wrong. Staff H stated that the program was intended to prevent the behavior.</td>
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**W 220**  
**Individual Program Plan**  
**CFR(s): 483.440(c)(3)(v)**  

The comprehensive functional assessment must include speech and language development.  

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #1) had a communication assessment that identified and addressed his communication needs. Client #1 had significant inappropriate behaviors that communicated his needs when he could not otherwise tell staff what he needed.
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<tr>
<td>W 220</td>
<td>The failure to provide Client #1 with a viable way to communicate resulted in Client #1 resorting to self-injurious, and other inappropriate behaviors to communicate.</td>
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<td>Findings included ...</td>
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<td>Record review of Client #1's Individual Habilitation Plan (IHP), dated 12/18/19, showed &quot;When [Client #1’s first name] starts to show signs that he is becoming overwhelmed or over stimulated staff members will attempt to communicate with him and meet his needs if possible.&quot; The IHP did not indicate how Client #1 communicated or how staff would attempt to communicate with him.</td>
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<td>Review of Client #1’s Positive Behavior Support Plan (PBS), signed 12/09/19, showed he exhibited physical aggression by assaulting others, throwing items (chairs), yelling, and screaming. The PBSP identified the function of the behaviors as his way of communicating he was frustrated, uncomfortable or displeased.</td>
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<td>Record review of Client #1’s Health Interdisciplinary Progress Notes, dated 11/26/19-12/18/19 showed:</td>
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<td>-Client #1 threw a hamper and hit his head against the shower wall.</td>
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<td>-Client #1 had an increase in behaviors and the Attendant Counselor Manager requested a nurse assess him.</td>
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<td>-Client #1 hit his head on a wall, had a bump on his head, and a red mark on his forehead. Client #1 threw himself off the bed onto the floor and banged his head on the wall.</td>
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<td>-Client #1 had an eye exam related to multiple</td>
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Self Injurious Behaviors (SIB) from hitting his head on the wall and floor. Client #1 went to the Emergency Room for evaluation of a potential head injury.
- Client #1 hit himself repeatedly in the face and side of his head.
- Client #1 pulled a cabinet over in his room, threw himself on the floor, slapped his face, and rolled around on the floor. Client #1 injured his finger during the SIB, and had bruising on his face.

Record review of Client #1's Communication Assessment, dated 10/14/19, showed:
- Client #1 would often repeat what staff stated, not his own words when staff spoke to him.
- No assessment of barriers to communication.
- No assessment of alternative means of communication.
- Only one recommendation, "Program development to address Yes No questions will be scheduled with house prior to his next IHP."

The Communication Assessment did not include recommendations for receptive or expressive communication, what services and programs the facility would provide for the Client, or any training programs to address the communication needs of the Client.

During an interview on 02/05/20 at 3:29 PM, Staff G, QIDP, stated that the communication assessment was current. Staff G also stated that the closer Client #1 came to discharge from the facility, the more important communication was. Staff G stated that since there was no consistent Speech Language Pathologist, they were not...
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>W 220</td>
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<td>able to implement communication programs.</td>
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<td>W 226</td>
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<td>INDIVIDUAL PROGRAM PLAN</td>
<td>W 226</td>
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<td>Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.</td>
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<td>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Individual Habilitation Plan (IHP), also referred to as an Individual Program Plan, for one Expanded Sample Client (Client #11) within 30 days of his admission. This failure prevented the Client from receiving aggressive, continuous, consistently implemented training based on his identified needs. Findings included ...</td>
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<td>Record review of Client #11's file showed he was admitted to the facility on <strong>/</strong>/20 and discharged on <strong>/</strong>/20, 31 days after admission to the facility. An IHP was not in his file. A Community Living Transition Checklist, undated, showed the facility did not develop an IHP.</td>
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<td>Record review of Code of Federal Regulations 483.440(c)(4) showed &quot;Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan.&quot;</td>
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<td>Record review of Client #11's facility document titled IHP Revision, dated 01/30/20, stated,</td>
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### Statement of Deficiencies and Plan of Correction

<table>
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<tr>
<td>Name of Provider or Supplier:</td>
<td>Rainier School Pat E</td>
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<tr>
<td>Street Address, City, State, Zip Code:</td>
<td>320 Ryan Road, Buckley, WA 98321</td>
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> "Since [Client #11's first name] is scheduled to move to "[supported living name]" on [date], the IDT had to continue the process of scheduling his 30-day IHP." The IHP revision also stated, "The primary reason for this meeting was to share with his new staff recommendations that would be beneficial for [Client #11's first name] needs."

During an interview on 02/06/20 at 9:30 AM, Staff W, Psychology Associate, stated that the facility held an IHP meeting so they could make recommendations to the community provider.

During an interview on 02/07/20 at 9:31 AM, Staff BB, Attendant Counselor Manager, that staff did not implement any formal training programs for Client #11 as the facility did not complete his IHP.

#### 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 that teaching plans contained clear and detailed instructions for staff to implement them correctly and consistently for one of six Sample Clients (Clients #4). Client #4's teaching programs using the washing machine; identify a penny; and duplicate numbers had insufficient detailed instructions for staff to implement. This resulted in staff not really knowing how to teach Client #4.

Findings included...
## SUMMARY STATEMENT OF DEFICIENCIES

### W 234

**Record review of Client #4's training program to "use the wash machine" showed it did not identify laundry soap as a material needed to run the program. In the teaching sequence it stated Client #4 was to add soap.**

Record review of Client #4's training program to "identify a penny" showed instructions for the reinforcer to be used by staff should identify what he had done correctly after the successful completion of the task. The reinforcer on the teaching plan said to say, "You did great today" but did not identify the task.

During an interview on 02/05/20 at 1:27 PM, Staff P, Attendant Counselor Manager (ACM), stated that for the "use wash machine" the laundry soap is added by pushing a button and the instructions could be clearer. Staff P stated that for the "identify a penny" program he would give staff instructions but would ask the staff how they would reinforce the program. He didn't expect staff would all do it the same way.

Observation on 01/30/20 at 1:59 PM at Hurlburt Hall showed Client #4 sat at a table with an Adult Training Staff (ATS). The ATS asked Client #4 if he wanted to do his numbers program (duplicate 3 numbers training program). Client #4 agreed and the ATS provided him with a worksheet and writing instrument. The ATS asked Client #4 to trace the numbers (1 to 10) written on the worksheet. Afterwards the ATS asked Client #4 to write the numbers she called out and proceeded to call out the numbers 1 to 10. The ATS stated if he wrote three different numbers correctly he would get a "+" for successfully
### W 234

**Continued From page 45**

**W 234**

Completing the task.

Record review of Client #4's training program to "duplicate 3 numbers" showed that there were no instructions for staff to have him trace the numbers 1 to 10 and then to write the numbers as the staff called them out. The training plan showed if Client #4 wrote three numbers correctly he would have completed the task successfully. The training plan did not identify that it had to be three different numbers.

During an interview on 02/05/20 at 9:09 AM, Staff R, Adult Training Specialist 3, stated that the instructions for Client #4's duplicate 3 numbers program were insufficient for staff to run the program correctly.

### W 242

**INDIVIDUAL PROGRAM PLAN**

**W 242**

**CFR(s): 483.440(c)(6)(iii)**

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

This STANDARD is not met as evidenced by:

Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #1) had training to increase his independence with grooming and for communication of his basic needs. This failure prevented Client #1 from gaining greater
Continued From page 46

independence in hygiene and prevented him from learning appropriate ways to communicate basic needs.

Findings included ...

**Communication**

Record review of Client #1's Positive Behavior Support Plan (PBSP), signed 12/09/19, showed he exhibited physical aggression by assaulting others, throwing items (chairs), yelling, and screaming. The PBSP identified the function of the behavior as his way of communicating he was frustrated, uncomfortable or displeased.

Record review of Client #1's Individual Habilitation Plan (IHP), dated 12/18/19, showed staff members would attempt to communicate with him when he became overwhelmed or overstimulated. The IHP showed that Client #1 had attempted communication classes, held in a group setting, but may have been too tired to participate. The IHP did not contain any training programs to assist the Client with communication.

**Grooming**

Record review of Client #1's Attendant Counselor Assessment, dated 11/07/19, showed he required physical assistance to shave.

Review of Client #1's training programs showed no training programs to help Client #1 learn to shave himself.

Review of Client #1's IHP, dated 12/18/19, showed no training plans to teach Client #1 to shave himself.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Rainier School Pat E  
**Address:** 320 Ryan Road, Buckley, WA 98321  
**Provider Identification Number:** 50G046  
**Survey Completion Date:** 02/07/2020

### Summary Statement of Deficiencies

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**During an interview on 02/05/20 at 3:29 PM, Staff G, Qualified Intellectual Disability Professional, stated that the IHP and training plans were current. Staff G stated that Client #1 would begin learning communication prior to his discharge to the community, potentially next year.**  
**PROGRAM DOCUMENTATION**  
**CFR(s): 483.440(e)(1)**  
**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 record review and interview, the facility failed to ensure staff documented data to show they implemented programs for two of six Sample Clients (Clients #4 and #5). This prevented the facility from correctly analyzing the programs to determine if the facility needed to update or revise the program to meet the Client's needs.**

**Findings included ...**

**Client #4**

**Record review of Client #4's training program for duplicating 3 numbers required that data be collected two times a week (Monday thru Friday). For the week beginning 01/13/20, data was only collected on 01/16/20.**
During an interview on 02/04/20 at 10:42 AM, Staff Q, Qualified Intellectual Disability Professional (QIDP) stated that there was data missing from the duplicating 3 numbers training program.

Client #5
Record review on 01/27/20 of the program and data collection sheet for Program Objective #1140.4 for Client #5 to walk on the crosswalk for 8 out 10 data sessions showed this program began in November 2019. The instructions showed data collection occurred three times a week. The data sheet for December 2019 showed staff documented data two times for the week of December 22 - 28, 2019.

During an interview on 02/06/20 at 9:16 AM, Staff B, QIDP, stated that there was data missing for the week of 12/22/19 - 12/28/19 for Client #5's Program Objective #1140.4.

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 one of six Sample Clients (Client #5) moved on to the next step when she achieved the objective. Client #5 achieved an objective to walk on the crosswalk with a verbal cue in December 2019. The staff still trained her on this objective in January 2020. There was no

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<tr>
<td>W 255</td>
<td>PROGRAM MONITORING &amp; CHANGE</td>
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<td>CFR(s): 483.440(f)(1)(i)</td>
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<tr>
<td>W 255</td>
<td>Continued From page 49 change made to the program until the end of January 2020. This failure delayed Client #5's learning progress and the opportunity to learn new skills. Findings included ... Review of Client #5’s file revealed an IHP Revision form, with an effective date of 11/07/19, for Objective 1140.4, a crosswalk program, that showed an estimated end date of 12/19/19. Record review on 01/27/20 of the program and data collection sheet for Program Objective #1140.4 for Client #5 to walk on the crosswalk with a verbal cue for 8 out 10 data sessions showed this program began in November 2019. Data collection started on 11/19/19 and went thru 01/26/20. The data sheets showed Client #5 had passed this objective in December 2019 and in January 2020 by 01/17/20. During an interview on 02/06/20 at 9:16 AM, Staff B, Qualified Intellectual Disability Professional, stated that the data showed Client #5 passed Objective 1140.4 in December and January. She stated that at some point she became aware that Client #5 was not following the program and the team decided to continue it through January. When asked for documentation of this decision, Staff B stated that the Interdisciplinary Team (IDT) may have been discussed it in a meeting, and Staff C, Attendant Counselor Manager, would have notes on the meetings. Record review of a Program Revision, effective date of 01/27/20, showed Program Objective 1140.4 stopped on 01/27/20, and 1140.5 began</td>
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</table>
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier
RAINIER SCHOOL PAT E

#### Street Address, City, State, Zip Code
320 RYAN ROAD
BUCKLEY, WA 98321

#### Summary Statement of Deficiencies
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<td>W 255</td>
<td>Continued From page 50 with a change from a verbal cue to a hint.</td>
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<tr>
<td>Record review of Alpine House Team Minutes, dated 12/17/19, provided by Staff C on 02/10/20 at 7:51 AM via e-mail, showed there was no mention of Client #5's Program Objective 1140.4 or concern that the data may be inaccurate.</td>
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<td>During a telephone interview on 02/10/20 at 2:45 PM, Staff B stated that the data was correct for Program Objective 1140.4. Staff B stated that Client #5 was not consistent in demonstrating the skill, and the IDT looked at why Client #5 was inconsistent in following all the steps learned thus far.</td>
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<td>Record review of an email sent by Staff A, Superintendent, on 02/11/20 at 1:02 PM to the Survey Team Lead, and forwarded to this Surveyor on 02/11/20 at 1:07 PM, showed the statement that the documents attached to her e-mail were, in part, related to the extended time frame for programs. The documents attached were Alpine House Team Minutes for 12/07/19 and 12/17/19. The Team Minutes for 12/07/19 did not mention Program Objective 1140.4 or the possibility that implementation was incorrect or inconsistent, requiring a need to continue it. The Team Minutes for 12/17/19 were in a previous paragraph.</td>
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#### Provider's Plan of Correction
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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#### Program Monitoring & Change

CFR(s): 483.440(f)(2)

At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.
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<tr>
<td>W 260</td>
<td>Continued From page 51</td>
<td>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Habilitation Plans (IHP)s for two of six Sample Clients (Clients #1 and #5) were updated to contain current accurate information. Client #1 engaged in Self-Injurious Behavior (SIB) serious enough to require hospital visits in the months leading up to his IHP created in December of 2019. The IHP indicated the facility no longer monitored SIB for Client #1 as it no longer occurred. Client #5’s IHP, reviewed on 01/27/20, contained information she needed to have a tooth extracted. Documentation in her dental file in the dental clinic indicated extraction of this tooth occurred on 05/18/18. These failures resulted in inaccurate information in the Clients’ treatment plans; lack of prevention, monitoring, and replacement behavior training for SIB that resulted in harm for Client #1; and presented a false representation of Client #5’s dental health. Findings included ... Client #1 Record review of Client #1’s Health Interdisciplinary Progress Notes showed the following entries: 09/19/19-Client #1 was agitated and hit another Client 11/19/19-Client #1 threw his plate of food across the room, screamed and attempted to hit his head against the wall. 11/26/19-Client #1 threw a hamper and hit his head against the shower wall. 12/10/19-Client #1 had an increase in behaviors and the Attendant Counselor Manager requested a nurse assess him.</td>
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Continued From page 52

12/11/19-Client #1 hit his head on a wall, had a bump on his head, and a red mark on his forehead. Client #1 threw himself off the bed onto the floor and banged his head on the wall.

12/11/19-Client #1 had an eye exam related to multiple Self-Injurious Behaviors (SIB) from hitting his head on the wall and floor. Client #1 went to the Emergency Room for evaluation of a potential head injury.

12/18/19-Client #1 hit himself repeatedly in the face and side of his head.

12/18/19-Client #1 pulled a cabinet over in his room, threw himself on the floor, slapped his face, and rolled around on the floor. Client #1 injured his finger during the SIB, and had bruising on his face.

Record review of Client #1’s Psychology Review, dated 10/02/19, for the month of September 2019, showed that Client #1 threw chairs when he was upset, and when agitated would, “band (sic) his head on the wall.”

Record review of Client #1’s Psychology Review, dated 01/08/20, for the month of December 2019, showed “SIB was severe enough to warrant padding his headboard and footboard as well as the walls around his bed.” and “became self-injurious again as well as throwing chairs ...”

Record review of Client #1’s Quarterly Drug Regimen Review, dated 12/18/19, showed “behaviors include SIB, aggressive (sic), hitting, throws chairs ...”

Record review of Client #1’s Individual Habilitation Plan (IHP) Revision, dated 12/11/19, showed the Hyak team met to discuss Client #1’s
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<td>W 260</td>
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<td>&quot;continuing physical and psychiatric issues that are causing him to SIB and exhibit distress. More recently, [Client #1’s first name] has been going into his room, laying down on his bed, then banging his head against the walls, his headboard, and his footboard.&quot;</td>
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<td>Record review of Client #1’s Nursing Care Plan 8094, dated 12/11/19, showed Client #1 was at risk for trauma related to his SIB.</td>
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<td>Record review of Client #1’s current IHP, dated 12/18/19, showed &quot;This year we will no longer will (sic) track self-injurious behaviors as it is not an issue. [Client #1’s first name] will sometimes pick at his scabs which does not serve as SIB.&quot;</td>
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<td>During an interview on 02/05/20 at 11:00 AM, Staff H, Psychology Associate, stated that Client #1 had exhibited SIB for the past few months and staff documented the incidents in his file.</td>
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<td>During an interview on 02/05/20 at 3:29 PM, Staff G, Qualified Intellectual Disability Professional (QIDP), stated that the IHP dated 12/18/19 was current and SIB was removed because the Client was no longer picking his scabs to make them bleed.</td>
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<td>Client #5 Record review on 01/27/20 of Client #5’s IHP, dated 06/20/19, showed, &quot;It was recommended by the Dentist [Staff U] on 6/12/19 that [Client #5’s first name] have tooth #16 extracted pending guardian consent. Will follow up.&quot; The IHP contained no follow up information related to guardian consent and extraction of tooth #16.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

50G046

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

C
02/07/2020

NAME OF PROVIDER OR SUPPLIER

RAINIER SCHOOL PAT E

STREET ADDRESS, CITY, STATE, ZIP CODE

320 RYAN ROAD
BUCKLEY, WA  98321

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<th>(X4) 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>(X5) COMPLETION DATE</th>
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| W 260             | Continued From page 54  
During an interview on 02/06/20 at 8:40 AM, Staff E, Dental Assistant, stated that the dentist's notes in the Dental Clinic showed Client #5 had tooth #16 extracted on 05/15/18.  
During an interview on 02/06/20 at 9:16 AM, Staff B, QIDP, acknowledged the entry in the IHP that indicated Client #5 needed to have tooth #16 extracted. She stated that she was not sure if Staff U extracted Client #5's tooth #16.  
COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(2)  
The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.  
This STANDARD is not met as evidenced by:  
Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #6) received dental services upon identification of a need by Staff U, Dentist. This failure caused Client #6 to live with a loose tooth that became worse over time, possibly contributing to Client #6's lack of eating and drinking sufficiently and becoming dehydrated.  
Findings included ...  
During an interview on 02/06/20 at 10:05 AM, Staff M, Physician, stated that she had requested a consult from Staff U on [redacted] before Client #6 went to the hospital, as she believed his tooth was a large contributing factor for why he was unable to eat, not feeling well, and failing to | W 260 | | | |
| W 356             | | | | |

This document was prepared by Residential Care Services for the Locator website.
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<td>W 356</td>
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thrive. She stated that Staff U responded but refused to remove the tooth as the Client was dehydrated, had a UTI, needed sedation, and he could not do it at that time.

Record review of the Dental Treatment Record for Client #6 showed a reference to tooth #20 in an entry dated 01/08/18. This entry showed tooth #20 was mobile and the plan was to "recall and re-evaluate tooth #20." There was no more mention of tooth #20 until Staff M requested an evaluation on 10/19. The entry dated 1/19 showed Staff U did a limited oral evaluation because of Staff M's request. The notes showed tooth #20 had become much looser than when last evaluated, and showed, "Hopeless tooth #20 2ndry [sic] to advanced periodontitis and periodontal abscess (chronic)." Staff U recommended acetaminophen as needed until extraction of the tooth occurred, and Staff M would prescribe an analgesic if needed. The note indicated extraction of tooth #20 would occur at the next dental visit when Client #6 received sedation. In between the 01/08/18 and 10/08/19 entries were two other entries dated 11/29/18 and 08/05/19. Neither of these entries mentioned tooth #20. The 08/05/19 entry showed only, "IHP [Individual Habilitation Plan] updated." The 11/29/18 entry showed the next visit would be, "Periodontal exam and dental treatment when client is sedated."

Record review of an IHP Revision, dated 10/14/19, showed Client #6 had two teeth removed and a feeding tube put in place while he was in the hospital from 19-19. The revision showed instructions for staff related to the care of the feeding tube, but not the extracted
### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:** Rainier School PAST E  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 320 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 356 | Continued From page 56 teeth. The Interdisciplinary Team would meet the following day to review dental concerns and other treatment issues. Record review of the 10/15/19 IHP Revision showed Client #6 would need a follow-up visit with Dental in three to four weeks, which would put it between 11/05/19-11/12/19. There was no mention of how to care for his mouth, or reference to any care plan, related to the removal of two teeth to ensure proper healing. Review of the Dental Treatment Record showed Staff U provided a full evaluation with treatment on 12/18/19. Review of the Dental Treatment Record for Client #6 showed an entry for 11/12/19 that staff reported Client #6 would not open his mouth to brush, and they were concerned there was a problem. Staff U documented he did a limited evaluation at Aspen House and identified poor oral hygiene that may have caused inflamed gums. Staff U documented that he provided oral hygiene and instructed staff to brush his teeth twice daily and floss once daily if Client #6 cooperated enough. W 358 | W 356 |
| W 358 | DOCUMENTATION OF DENTAL SERVICES  
CFR(s): 483.460(h)(1)  
If the facility maintains an in-home dental service, the facility must keep a dental summary maintained in the client's living unit. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six Sample Clients | W 358 |
## Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

RAINIER SCHOOL PAT E

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

320 RYAN ROAD
BUCKLEY, WA 98321

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<td>(Client #5) had a current dental summary maintained in her file at the house. The dental section of Client #5's file contained two dental assessments, neither of which identified the extraction of a tooth that had occurred. Due to this failure, the staff who cared for Client #5 did not have the information needed in order to appropriately care for her dental needs.</td>
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<td>Findings included ...</td>
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<td>Review of Client #5's file revealed two Dental Assessments, dated 05/15/18 and 07/26/19, that identified the need to extract tooth #16 pending guardian consent. The one instruction for staff was to help with brushing twice a day.</td>
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<td>Record review of Client #5's Individual Habilitation Plan, dated 06/20/19, showed a recommendation by the dentist to have tooth #16 extracted pending guardian consent. It also showed follow up would occur.</td>
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<td>During an interview on 02/06/20 at 8:40 AM, Staff E, Dental Assistant, stated that Staff U, Dentist, extracted Client #5's tooth #16 on 05/15/18 per the dental notes in the dental clinic. When shown the assessments from the house file, she stated that Staff U probably did not remove the need to extract tooth #16 when he updated the assessments.</td>
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<td>SPACE AND EQUIPMENT</td>
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<td>CFR(s): 483.470(g)(2)</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>W 436</td>
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The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide training for one of six Sample Clients (Client #1) to use and maintain his eyeglasses. This failure prevented Client #1 from learning to use and take care of his eyeglasses.

Findings included...

Record review of two of Client #1's Annual Optometry Consults, dated 06/20/18 and 11/13/19, showed the ophthalmologist intended for the Client to wear his prescription eyeglasses full time and staff should develop a program to increase the amount of time he wore them.

Observation at Hyak house on 01/29/20 at 2:03 PM showed Client#1 went to a cupboard in the TV room, got a pair of eyeglasses, put them on, and went to a dining room table. Direct Care Staff took Client #1's eyeglasses off, cleaned them, and returned them to Client #1.

Observation at Pine Hall Room #130 (Adult Training Program (ATP)) on 01/30/20 at 1:09 PM showed Client #1 sat on a couch. Client #1 was not wearing eyeglasses.
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<td>W436</td>
<td>Continued From page 59</td>
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<td>Record review of Client #1's Individual Habilitation Plan, dated 12/18/19, showed Client #1 had a training program at ATP to point to his name. Record review of Client #1's Service Care Plan #1106 showed staff would ask Client #1 to wear his eyeglasses twice a day. Documentation on the care plan showed Client #1 wore his glasses 76 times of the 82 opportunities that staff documented. There was no plan identified to help him learn to wear his glasses all the time as recommended by the ophthalmologist, learn to store them appropriately, or learn when and how to clean them. During an interview on 02/05/20 at 9:41 AM, Staff F, Attendant Counselor Manager, stated that the house team would determine if Client #1 needed a formal program.</td>
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<td>W460</td>
<td>FOOD AND NUTRITION SERVICES</td>
<td>CFR(s): 483.480(a)(1)</td>
<td>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one of six Sample Clients (Client #1) received additional fiber and prune juice as ordered by a facility physician. This failure resulted in medical staff believing he was receiving all interventions they had prescribed to treat severe constipation and potentially contributed to Client #1 receiving</td>
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unnecessary antipsychotic medications, when the physician increased his medications rather than treat his constipation.

Findings included...

Record review of the Hyak House Client Dietary List, printed 01/27/20, showed Client #1's diet included "1 scoop fiber powder BID" (BID means twice a day) and "8 ounces of prune juice daily".

Record review of Client #1's physician's diet order, dated 10/13/10, showed he was to have one scoop of fiber powder twice a day and 8 ounces of prune juice each morning.

Observation at Hyak House on 01/31/20 at 6:57 AM showed Staff Y assisted Client #1 with dishing up his breakfast. The dining book was on the counter but was not open. Staff Y did not mix fiber into Client #1's food. Client #1 did not have prune juice served with breakfast.

Record review of Client #1's physician orders, dated 12/18/19, showed he was prescribed three different medications to treat his chronic constipation, and had multiple medication changes recently to treat ongoing constipation.

During an interview on 01/31/20 at 9:08 AM, Staff Y stated that two Clients had fiber mixed in their food but Client #1 was not one of them. Staff Y stated that Client #1 was to get prune juice. When asked if Client #1 received prune juice, Staff Y answered, "Yes. I think."

Observation at Hyak House on 01/29/20 at 2:04 PM showed staff brought Client #1 a glass of
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<td>W 460</td>
<td>Continued From page 61</td>
<td>apple juice, yogurt and a Multigrain bar from the kitchen for his snack. Staff did not add fiber to his juice or yogurt. Record review of Client #1's training program for making a snack, dated February 2020, showed he was to receive two scoops of fiber twice a day and 8 ounces of prune juice once a day. There were no instructions to staff to provide the fiber or prune juice during the snack. During an interview on 02/05/20 at 4:04 PM, Staff Z, Registered Nurse, stated that staff serving the meal would provide the fiber and add it to his meals but there was no place to document that staff provided the fiber or prune juice.</td>
<td>W 460</td>
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Tag Number W104

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

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. We do not agree with this citation based on our assessment that adequate staffing was provided. The off campus trip in question was reviewed. Clients #1, #7, #8, #10 and #14 were not scheduled to exit the vehicle during the off campus trip and contingencies for exiting the vehicle were considered. However, Standard Operating Procedure 3.17 Off-Campus Leisure Trips will be revised to update guidelines on client supervision levels. Off Campus trip form RS25-30A will be updated to improve oversight for all off campus trips.

The Program Area Team E Taskforce completed a root cause analysis and found that the facility disagrees with Residential Care Services finding of not a having a system in place to prevent abuse, neglect mistreatment. However the policy Developmental Disabilities Administration 12.02 Residential Habilitation Center Incident Investigations did not provide clear instructions on the outside entities (Special Investigations Unit) role in completing a regulatory investigation nor did the Rainier School Standard Operating Procedure 2.25 Incident Management direct the appointing authority to make a finding. The facility asserts that based on information provided the facility did and does take appropriate disciplinary actions.

The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The finding show that our current background check system of completing and storing background checks led to an inconsistent process among multiple departments. The facility could not produce background checks for staff CC and DD. The backgrounds check for staff X did not have the correct spelling of her last name. The facility crossed out the misspelled name and wrote the correct spelling on the page. There was no evidence the facility ran the background check through the system with the correct spelling of her name.

The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. It was determined that no protocol existed to address a client’s personal refrigerators. This caused a failure to ensure that client #10’s refrigerator was monitored for cleanliness, maintenance, and possible food borne illness.

The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The findings show that the facility Standard Operating Procedure 4.20 Tuberculosis, did not address refusal of testing by needle and as a result client #3 was not screened for latent tuberculosis until three weeks later when a symptom review and an x-ray were completed.

2. Quality Assurance will update Standard Operating Procedure 3.17 Off-Campus Leisure Trips and revise the off campus trip form RS 25-30A. All facility staff will be trained on the updated Standard Operating Procedure 3.17 Off-Campus Leisure Trips and off campus trip form RS 25-30A.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Developmental Disabilities Administration 12.02 Residential Habilitation Center Investigations will be revised to include language that directs the outside entity (Special Investigations Unit) to provide a regulatory investigation that provides a recommendation if abuse, neglect occurred so that the appointing authority can make a determination if abuse, neglect, or mistreatment had occurred. This will include direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, and protect client rights, ensuring all clients receive required programming and services. Rainier School Standard Operating Procedure 2.25 Incident Management will be revised to include the requirement of addressing direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, protect client rights, ensuring all clients receive required programming and services and distinct delegation of appropriate corrective action being taken by the appointing authority for allegations determined to meet the criteria of abuse neglect or mistreatment. The investigator responsible for investigation #9005 of client #13 will attend Investigator Core Training. Quality Assurance Incident Management will reopen investigation #9005 of client #13 and complete an addendum to address the discrepancies regarding staff knowledge of client #13 supervision level. An additional investigator has been hired to the Quality Assurance Incident Management team to disperse work load. Quality Assurance Incident Management will also work with the Special Investigations Unit should the Quality Assurance Incident Management get inundated with a high volume of investigations.

A system will be developed to address management of background checks for all staff working at the facility. All administrative staff responsible for running and receiving background checks will be trained to follow the new background check system, which will include the filing of all background checks. The Assistant Superintendent will complete a review of all background checks, including Character Competency Suitability Reviews for all current employees.

The Hyak Attendant Counselor Manager will ensure that the freezer is defrosted, food is dated, and any expired food is thrown away. The environmental checklist will be updated to include personal client refrigerators. The Hyak Team will assess client #10 to determine if training is needed to maintain his refrigerator.

A protocol will be developed by the medical department to address management of tuberculosis screening for clients admitted who are unable to receive 2-step purified protein derivative or Blood test. A workgroup will be developed to update Standard Operating Procedure 4.20 Tuberculosis with the new protocol for management of tuberculosis screening for clients admitted who are unable to receive the 2-step purified protein derivative or blood test. All nursing staff, admissions team, lab technician and physicians will be trained to follow the new admission tuberculosis screening protocol.

3. The Program Area Team E Director or designee will review all Program Area Team E off campus trips to ensure policy 3.17 Off-Campus Leisure Trips is followed and adequate staffing levels for all off campus trips occur.
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Rainier School Program Area Team E
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Initial peer reviews will completed at 100% of all Staff D's investigations for the next 30 days. All concerns will be discussed and corrected at the time of the peer review.

The Assistant Superintendent or designee will complete a random sample of background checks for 10 employees each quarter for 12 months. This review will include; if the background form able to be located within 24 hours and is the form completed accurately and completely.

Refrigerator maintenance will be monitored monthly by the Attendant Counselor Manager through the updated monthly environmental checklist.

The Infection Control nurse or designee will monitor all new admissions to ensure tuberculosis testing is being completed within 3 days of admission per updated Standard Operating Procedure 4.20 Tuberculosis.
The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, Infection Control Nurse, Program Area Team E Director, and the Superintendent or designee(s) will be responsible for the implementation of the acceptable plan of correction.

[Signatures]
Title

[Signature]
Date

3
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Tag Number W125

Regulation: Protection of client 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.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Psychology Associate failed to follow Standard Operating Procedure 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans to include an adaptive replacement behavior training to reduce the need of the restriction of a locked closet due to client #7 defecating and urinating (tracked as defecating in Positive Behavioral Support Plan) in his closet. This failure prevented the client from having free access to his personal belongings. The Positive Behavioral Support Plan did not include an adaptive replacement behavior training for how client #7 would learn to discontinue the inappropriate behaviors in order to gain free access to his belongings. The functional assessment did not identify an adaptive replacement behavior associated with the function of defecating and urinating. The lack of communication amongst the Hyak Interdisciplinary Team led to the breakdown between the client’s treatment plans. The Habilitation Plan Administrator failed to provide oversight of the Individual Habilitation Plan. This failure resulted in a lack of replacement behavior training to reduce the need for a restriction.

2. The Psychology Associate for client #7 will be trained on 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and Psychological Assessment for client #7. The Psychology Associate will train staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior to specifically address the reduction of the locked closet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development to improve teamwork and communication.

3. Psychology monthly reviews will be revised to a standard format to include a section to monitor reduction plans for restrictive procedures. The review template will include clear instructions on how to complete each section of the Psychology monthly review. The Director of Programs or designee will take a random sample of 16 Program Area Team E client reviews (2 per living unit) per quarter for 12 months to ensure this is being completed. Quality Assurance will initially review all Positive behavioral support plans that may have restrictions and cross reference them with the informed consent to ensure they are accurate. Thereafter, results of this sample will be sent to the Interdisciplinary Team for review and any needed follow up.
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The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Director of Programs, Staff Development, and the Quality Assurance Incident Management Director or designee(s) will be responsible for the implementation of the acceptable plan of correction.

[Signatures and Dates]

Title
Signature
Date
Plan of Correction for Statement of Deficiency

Rainier School Program Area Team E

Date of SOD: 02/07/2020

Event ID# C5LM11

W127 Protection of Client Rights

Regulation: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. While we do not agree with the findings, we do recognize the facility failed to develop a plan to prevent this abuse. The facility failed to establish guidelines for Interdisciplinary Team’s to follow should a client have a Vulnerable Adult Protection Order. The Tyee team failed to develop and implement a plan of protection for client #3, which would have outlined steps to take should the Alleged Perpetrator attempt to visit client #3. This failure resulted in the potential for client #3 to be subjected to physical, verbal, sexual or psychological abuse or punishment.

The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The staff assigned to client #13 was assisting another client outside his post and was not aware client #13 had left the house. This failure put client #13 at risk for possible abuse, neglect, and mistreatment. An outside entity (Special Investigations Unit) did not provide a conclusion that possible neglect occurred when it failed to provide the supervision services necessary to meet client #13’s needs.

2. If a legal guardian identifies that they do not wish to have a client have contact with another person, the Interdisciplinary Team will inform them of House Bill 1402 and notify the Superintendent so the Facility can prevent interaction with the person of interest for 14 days. During this time, the team will develop a limited protection plan while the guardian is seeking a Vulnerable Adult Protection Order. When a Vulnerable Adult Protection Order is provided, the Interdisciplinary Team, working with the Resource Guardianship Coordinator will develop a protection plan for the client to prevent physical, verbal, sexual or psychological abuse or punishment. All facility Attendant Counselor Manager’s, Habilitation Plan Administrator’s Psychology Associates, Duty Officers, Executive Staff, Intake and Placement Coordinators and Facility Medical Doctors will be trained on House Bill 1402.

Developmental Disabilities Administration 12.02 Residential Habilitation Center Investigations will be revised to include language that directs the outside entity (Special Investigations Unit) to provide a regulatory investigation that provides a recommendation if abuse, neglect occurred so that the appointing authority can make a determination if abuse, neglect, or mistreatment had occurred. This will include direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, and protect client rights, ensuring all clients receive required programming and services. Rainier School Standard Operating Procedure 2.25 Incident Management will be revised to include the requirement of addressing direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, protect client rights, ensuring all clients receive required programming and services and distinct delegation of appropriate corrective action being taken by the appointing authority for allegations determined to meet the criteria of abuse neglect or mistreatment. A review of Program Area Team E post positions for all 8 houses will be completed. A new
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standardized template will be created for each post position. The new template will provide additional clarity and instructions for staff and includes contingency plans. All active treatment schedules will be reviewed and revised as needed. A thorough review of all Individual Habilitation Plan and Positive Behavioral Support Plans that address elopement, wandering and individuals requiring additional supervision. Revisions of Individual Habilitation Plan and Positive Behavioral Support Plan’s to provide clarity on how frequently to check supervision of clients that do not have protective supervision or 1:1 requirement while on the house. Client plans will be reviewed for establishment of check in procedure for individuals that have independence on campus.

3. The Resource Guardianship Coordinator will review all Vulnerable Adult Protection Orders and report any findings to the Superintendent, Program Area Team E Director or designee, and Interdisciplinary Team. The Program Area Team E director or designee will review completed plans and submit them to the Superintendent. Training on House Bill 1402 will be added to the staff development yearly training for all current employees as well as to the new employee orientation training.

The Facility will review all investigations completed by outside entity (Special Investigations Unit). The facility will meet on a weekly basis to review the status and language provided within the outside entity investigation to ensure that is provides the proper components of a regulatory investigation to include direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, protect client rights, ensuring all clients receive required programming and services. The Program Area Team E Director will review post positions any time a new level of supervision is added or decreased and when a client moves in or out of the house. Once the post positions have been updated of all Program Area Team E clients to the Quality Assurance Department will initially review 100% of the post positions to ensure they are on the correct form, and the levels of supervision are addressed. Thereafter, Quality Assurance will review one clients post position per house per quarter for 12 months for compliance. Staff will check the whereabouts of clients in their post who remain on the living unit every ½ hour as they provide active treatment.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Residential Guardianship Resource Coordinator, facility Quality Assurance Incident Management Director, Superintendent, Director of Programs, Program Area Team E Director, Staff Development, Director of Programs, Nurse Educator, and Superintendent or designee(s) will be responsible for the implementation of the acceptable plan of correction.
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Rainier School Program Area Team E
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Event ID# C5LM11

Tag Number W128

Regulation: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. We do not agree with this citation, however based on our assessment, documentation was not done and provided to prove sufficient evidence that the change of psychiatric medication was done appropriately. The team failed to properly document whether issues associated with chronic constipation were addressed prior to increasing a psychiatric medication. The Interdisciplinary Team failed to tie together a timeline that lead to the decision to increase psychiatric medications. When client #1 appeared sedated staff failed to complete "see and tell" documents to notify nursing personal. The team failed to document that client #1 has mannerisms that can make him appear sedated, which are related to his experience of autism spectrum disorder.

2. The Program Area Team E Medical Department and Program Area Team E core staff (including Hyak Interdisciplinary Team) will be trained on Developmental Disabilities Administration policy 5.16 Psychotropic Medications. All Program Area Team E Interdisciplinary Team’s will meet to identify clients who are chronically constipated. A constipation protocol will be developed to document that constipation has been resolved after it had been identified. When psychiatric medications changes are made there will be a section added to the psychiatric assessment to document how any medical concerns have been resolved. The house-team form that is being standardized will include a section for potential medical issues that could be contributing to behavioral or psychiatric concerns. All Hyak staff and Program Area Team E employees will be inserviced on the process of completing "see and tell" forms by the Nurse Educator. The psychology associate and occupational therapist will update their assessments to include mannerisms that can make client #1 appear sedated (eye squinting), which are related to his experience of autism spectrum disorder (sensory issues). Due to these significant issues not being properly assessed and documented, the Habilitation Plan Administrator will schedule an Individual Habilitation Plan meeting to include updated assessments and documentation for client #1. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development to improve team work and communication.

3. For a period of 12 months, the Medical Director or designee will take a random sample of 10 Program Area Team clients per quarter who have had psychiatric medication changes to ensure documentation of resolved medical concerns has been completed. For a period of 12 months the Superintendent or designee will take a random sample of 10 clients per quarter who have identified chronic constipation to ensure documentation has been completed. The Program Area
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Rainier School Program Area Team E
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Team E Assistant Director or designee will review the updated Individual Habilitation Plan for client #1 to ensure the changes have been included.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Quality Assurance Incident Management Director, Director of Programs, Medical Director, and Program Area E Director or designee will be responsible for the implementation of the acceptable plan of correction.

[Signature]
Title

[Signature]
Date

3/30/2020
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Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Tag Number W137

Regulation: The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients gave the right to retain and use appropriate personal possessions and clothing.
1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The facility failed to safeguard the personal property of client #12 when staff did not document his bike on his personal property record. This failure prevented the facility from identifying that client #12’s bicycle was stolen. Staff failed to follow Standard Operating Procedure 3.14 Client Personal Property resulting in client #12’s bike not being identified in his personal property record. Thus, not being able to identify his bike being stolen.

2. Quality Assurance updated Standard Operating Procedure 3.14 Client Personal Property on January 27, 2020. Client #12’s inventory will be updated onto the new inventory form RS 00-32 following the guidelines stated in Standard Operating Procedure 3.14 Client Personal Property. The San Juan Attendant Counselor Manager, Habilitation Plan Administrator and Direct Care Staff will be in-serviced on Standard Operating Procedure 3.14 Client Personal Property. The San Juan Interdisciplinary Team will meet to discuss possible replacement of client #12’s bike. The Habilitation Plan Revision will be reviewed by Program Area Team E Director or designee.

3. All facility staff will be trained on the updated Standard Operating Procedure 3.14 Client Personal Property. All Program Area Team E inventories will be updated onto new form RS 00-32, following the guidelines of the updated Standard Operating Procedure 3.14 Client Personal Property.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and the Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date 3/30/2020
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Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W138

Regulation: The facility must ensure the rights of all clients. Therefore, the facility must ensure that each client is dressed in his or her own clothing each day.

1. Program Area Team E completed a root cause analysis of the occurrence leading to the citation. The Hyak Interdisciplinary Team failed to ensure clients #1, #7, and #8 wore their own socks when house staff did not mark their personal belongings with their names. This failure resulted in client’s #1, #7, and #8 using stock items and not their own clothing. The Hyak Interdisciplinary Team failed to follow Standard Operating Procedure 3.14 Client Personal Property resulting client’s #1, #7, and #8 using stock items, and not their own clothing.

2. Quality Assurance updated Standard Operating Procedure 3.14 Client Personal Property on January 27, 2020 and will revise to address how to inventory specific items, including socks. Clients #1, #7, and #8 will have their inventories updated to the new inventory form RS 00-32. All Program Area Team E Attendant Counselor Managers and Habilitation Plan Administrators will review all clients wardrobe for clothing and ensure it is marked with the client name and house per Standard Operating Procedure 3.14 Client Personal Property and report findings to the Program Area Team Director or Designee.

3. Program Area Team E Attendant Counselor Managers, Direct Care staff and Habilitation Plan Administrator’s will be trained on Standard Operating Procedure 3.14 Client Personal Property. All Program Area Team E inventories will be updated onto new form RS 00-32, following the guidelines of the updated Standard Operating Procedure 3.14 Client Personal Property.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Quality Assurance Incident Management Director, and the Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
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Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

W149 Staff Treatment of Clients

Regulation: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Program Area Team E completed a root cause analysis of the occurrence leading to the citation. It was determined the facility failed to correctly categorize the incident for client #13 which resulted in the Residential Habilitation Center investigators investigating the event versus the Special Investigations Unit completing the investigation. However at the time Special Investigations Unit did not have authority per Developmental Disabilities Administration Policy 12.01 Incident Reporting and Management for Developmental Disabilities Administration Employees, 12.02 Residential Habilitation Center Investigations and 5.13 Protection From Abuse Mandatory Reporting to make the determination of a finding of abuse, neglect or mistreatment.

2. The Quality Assurance Incident Management will be retrained on categorizing events. Developmental Disabilities Administration 12.02 Residential Habilitation Center Investigations will be revised to include language that directs the outside entity (Special Investigations Unit) to provide a regulatory investigation with enough information that the appointing authority can make a determination if abuse, neglect, or mistreatment had occurred. This will include direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, and protect client rights, ensuring all clients receive required programming and services. Rainier School Standard Operating Procedure 2.25 Incident Management will be revised reflect changes made in Developmental Disabilities Administration Policy 12.02 Residential Habilitation Center Incident Investigations. The Special Investigations Unit and Quality Assurance Incident Management will be retrained to the newly revised Developmental Disabilities Administration Standard Operating Procedure 12.02 Residential Habilitation Center Incident Investigations and Standard Operating Procedure 2.25 Incident Management.

3. The facility will meet on a weekly basis to review the status and language provided within all investigations that include staff allegations of abuse, neglect, and mistreatment that have resulted in staff being placed on alternate assignment. This will be done to ensure that it provides the proper components of a regulatory investigation to include direction on resolving discrepancies of information discovered in the investigation, provide recommendations for safeguarding, protect client rights, ensuring all clients receive required programming and services. Levels of discipline will assessed by the Superintendent at this time.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Quality Assurance Incident Management Director, and Superintendent or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

[Signature] 3/30/2020

Date
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Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W152

Regulation: The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The finding show that our current background check system of completing and storing background checks led to an inconsistent process among multiple departments. The facility could not produce background checks for staff CC and DD. The backgrounds check for staff X (believed to also be staff Y included in the citation) did not have the correct spelling of her last name. The facility crossed out the misspelled name and wrote the correct spelling on the page. There was no evidence the facility ran the background check through the system with the correct spelling of her name.

2. A system will be developed to address management of background checks for all staff working at the facility. All administrative staff responsible for running and receiving background checks will be trained to follow the new background check system, which will include the filing of all background checks. The Assistant Superintendent will complete a review of all Character Competency Suitability Reviews for all current employees who have had a Character Competency Suitability Review.

3. The Assistant Superintendent or designee will complete a random sample of background checks for 10 employees each quarter for 12 months. This review will include; if the background form is able to be located immediately and that the form completed accurately and completely.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Superintendent or designee will be responsible for the implementation of the accepted plan of correction.

Title: [Signature] [Date: 03/20/2020]
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Tag Number W154

Regulation: The facility must have evidence that all alleged violations are thoroughly investigated.

1. Root cause analysis of the occurrence leading to the citation was conducted. It was determined that the investigation for client #13 did not include discrepancies of the progress note regarding staff knowledge of client #13 supervision level as the investigator assigned to complete the investigation was new and his first assigned investigation. A peer review of the investigation was not completed until February 5th, 2020 as the incident management office were assigned 47 investigations in January, as a result of the delay in the peer review this may have identified the discrepancies in the new investigators report regarding staff’s knowledge of client #13 supervision level.

2. The investigator responsible for investigation #9005 of client #13 will attend Investigator Core Training. Quality Assurance Incident Management will reopen investigation #9005 of client #13 and complete an addendum to address the discrepancies regarding staff knowledge of client #13 supervision level. An additional investigator has been hired to the Quality Assurance Incident Management team to disperse work load. Quality Assurance Incident Management will also work with the Special Investigations Unit should the Quality Assurance Incident Management get inundated with a high volume of investigations.

3. Initial peer reviews will be completed at 100% of all Staff D’s investigations for the next 30 days. All concerns will be discussed and corrected at the time of the peer review.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director or designee will be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
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Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W159

Regulation: Each client’s active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

1. Root cause analysis of the occurrence leading to the citation was conducted. It was determined that the facility failed to provide oversight for integration, coordination and monitoring of Individual Habilitation Plan’s. This failure led to inaccurate Individual Habilitation Plan’s, lack of active treatment, for clients #1, #4, #5, #7 and #11. As well as a violation of client #7’s right to access his personal possession, and client #4 had the potential of receiving the incorrect diet.

2. For client #1 The Hyak Interdisciplinary Team will be trained on completing assessments and formally implementing them through the Individual Habilitation Plan by the Program Area Team E Assistant Director or designee. The Attendant Counselor Manager will complete a new Attendant Counselor assessment on client #1. The Habilitation Plan Administrator will review client #1’s Attendant Counselor assessment along with the Interdisciplinary Team and determine prioritized needs for client #1. The Habilitation Plan Administrator will revise the Individual Habilitation Plan for client #1. The Psychology Associate will update the Positive Behavioral Support Program and Psychological Assessment for client #1 to address any training needs. The Program Area Team E Assistant Director will review all new assessments and plans developed for client #1 to ensure a focused individualized program plan has been developed. The Interdisciplinary Team will train Hyak Direct Care Staff on any changes in the Individual Habilitation Plan, Positive Behavioral Support Plan and formal programs. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development. The Speech Language Pathologist will be trained on completing thorough communication assessments and formally implementing them through the Individual Habilitation Plan by the Director of Programs or designee. The Speech Language Therapist will complete a new communication assessment on client #1, with oversight from the Therapies supervisor. The communication assessment will include recommendations for barriers of communication and alternative means of communication. The communication assessment will also include recommendation(s) for any need in receptive or expressive communication. The Habilitation Plan Administrator will review client #1’s communication assessment along with the Interdisciplinary Team, which is to include the Speech Language Pathologist and determine prioritized needs specific for client #1. The Habilitation Plan Administrator will revise the Individual Habilitation Plan for client #1. The Psychology Associate will update the Positive Behavioral Support Plan and Psychological Assessment for client #1 to address any communication training needs based on the updated communication assessment. The Hyak
Interdisciplinary Team will be trained on Standard Operating Procedure 3.06 Positive Behavior Support Plans and Developmental Disabilities Administration policy 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and the Psychological Assessment for client #1. The Psychology Associate will train staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior and daily behavior tracking sheet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment.

For client #4 the Habilitation Plan Administrator will revise the Individual Habilitation Plan to include current and accurate prescribed diet. The Program Area Team E Assistant Director will review the Individual Habilitation Plan to ensure it contains the current diet and that it is accurate.

For client #5 the dentist will update his assessment to note client #5’s current dental health. The Dental office will review all Program Area Team E dental assessments and update as needed to ensure all Program Area Team E clients’ dental health is current and accurate. The Dentist will ensure the Interdisciplinary Teams are provided with any assessments that have been modified. The Superintendent or designee will review the Dentist’s performance and act accordingly based on their review.

For client #7 The Hyak Interdisciplinary Team will be trained on Standard Operating Procedure 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and the Psychological Assessment for client #7. The Psychology Associate will train staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior to specifically address the reduction of the locked closet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development to improve team work and communication.

For client #11 Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement will be updated to clarify the intake process regarding active treatment services. The Placement coordinators, Program Area Team E Habilitation Plan Administrators, Psychology Associate, Attendant Counselor Managers, Assistant Director, and Director will be trained on Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement, for intake of new clients.
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3. The Program Area Team E Assistant Director or designee will review client #1’s updated Individual Habilitation Plan and will randomly attend 3 Individual Habilitation Plan’s for Hyak house for the next 12 months. The Program Area Team E task force will review all of Hyak’s current Habilitation Plans.

The Director of Programs or designee will review 100% of all communication assessment completed by the Speech Language Pathologist for 30 days. All concerns or issues will be addressed between the Speech Language Pathologist and the Director of Programs or designee and corrected prior to submitting the completed communication assessment. The Program Area Team E Assistant Director or designee will review all new annual Individual Habilitation Plan documents for all Hyak clients to ensure a focused individualized program plan has been developed the Individual Habilitation Plan for the next 12 months. Psychology monthly reviews will be revised to include a section for potential new challenging behaviors. The review template will include clear instructions on how to complete each section of the Psychology monthly review. The new lead Psychologist will take a random sample of 16 quarterly reviews to ensure this is being completed. Standardized house team forms will be developed that will identify potential new challenging behaviors.

For client #4: The Program Area Team E Assistant Director will review all Individual Habilitation Plan’s for accuracy for 12 months. Quality Assurance will review a random sample of 16 clients Individual Habilitation Plan’s (2 per house) to ensure the Individual Habilitation Plan and the diet order is congruent.

For client #5 Quality Assurance will review a random sample of 16 Program Area Team E clients (2 per living unit) quarterly to ensure dental assessments are current and accurate. Results of this sample will be sent to the Interdisciplinary Team for review and any needed follow up.

For client #7 The Hyak Interdisciplinary Team will be trained on Standard Operating Procedure 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and the Psychological Assessment for client #7. The Psychology Associate will train staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior to specifically address the reduction of the locked closet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development to improve team work and communication.

For client #11 Program Area Team E Director or designee will review all short term or emergent stays to verify active treatment services for 12 months.

The plan of correction will be fully implemented no later than March 23rd, 2020.
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4. The facility Quality Assurance Incident Management Director, Superintendent, Director of Programs, Program Area Team E Director, and Superintendent or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title  Signature  Date

3/30/2020
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Event ID# CSLM11

Tag Number W186

Regulation: The facility must provide sufficient Direct Care Staff to manage and supervise clients in accordance with their individual program plans.

1. Root cause analysis of the occurrence leading to the citation was conducted. Although the facility does not agree with this citation, it was stated that the facility needed to provide clearer post instructions to Chelan house to meet the supervised needs of client #13. This failure led to client #13 leaving the house and Direct Care Staff not maintaining his protective supervision status per his Positive Behavioral Support Plan, putting client #13 in jeopardy for harm, exploitation or possible death.

2. A review of Program Area Team E post positions for all 8 house will be completed. A new standardized template will be created for each post position. The new template will provide additional clarity and instructions for staff and includes contingency plans. All active treatment schedules will be reviewed and revised as needed. A thorough review of all Individual Habilitation Plan and Positive Behavioral Support Plans that address elopement, wandering and individuals requiring additional supervision. Revisions of Individual Habilitation Plan and the Positive Behavioral Support Plans to provide clarity on how frequently to check supervision of clients that do not have protective supervision or 1:1 requirement while on the house. Client plans will be reviewed for establishment of a check in procedure for individuals that have independence on campus.

3. The Program Area Team E Director or designee will review post positions any time a new level of supervision is added or decreased and when a client moves in or out of the house. Once the post positions have been updated for all Program Area Team E clients, the Quality Assurance Department will initially review 100% of the post positions to ensure they are on the correct form, and the levels of supervision are addressed. Thereafter, Quality Assurance will review one clients post position per house per quarter for 12 months for compliance. Staff will check the whereabouts of clients in their post who remain on the living unit every 1/2 hour as they provide active treatment. The Attendant Counselor Manager will in-service all of the employees assigned to the living unit on the Post Positions, ensuring that they know what their obligation is for that specific post. Should staff need to deviate from their assigned post position they will need to let the shift charge and or the ACM know and assign coverage for their post. Should any employee not follow their assigned post position, the Attendant Counselor Manager of the employee may take appropriate disciplinary action up to and including dismissal.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, Attendant Counselor Manager, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Title

Signature

Date

3/30/2020
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W195

Regulation: The facility must ensure that specific active treatment services requirements are met.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Habilitation Plan Administrator for client #1 failed to ensure assessments were accurate and individualized specific to client #1. The Interdisciplinary Team did not collaborate to develop a program based on client #1’s needs and then focus formal programming on those needs.

While we don’t agree with this finding, it was stated that client #11 was accepted to the facility for purpose other than for active treatment, thus resulting in the Interdisciplinary Team failing to follow Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement by ensuring that client #11 had a developed Individual Habilitation Plan within 30 days of placement and provided active treatment during his stay.

2. The Hyak Interdisciplinary Team will be trained on completing assessments and formally implementing them through the Individual Habilitation Plan by the Program Area Team E Assistant Director or designee. The Attendant Counselor Manager will complete a new Attendant Counselor assessment on client #1. The Habilitation Plan Administrator will review client #1’s Attendant Counselor assessment along with the Interdisciplinary Team and determine prioritized needs for client #1. The Individual Habilitation Plan Administrator will revise the Individual Habilitation Plan for client #1. The Psychology Associate will update the Positive Behavioral Support Plan and Psychological Assessment for client #1 to address any training needs. The Program Area Team E Assistant Director will review all new assessments and plans developed for client #1 to ensure a focused individualized program plan has been developed. The Interdisciplinary Team will train Hyak Direct Care Staff on any changes in the Individual Habilitation Plan, Positive Behavioral Support Plan and formal programs. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development.

For client #11; Quality Assurance will update Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement to clarify the intake process regarding active treatment services. The Admission and Placement coordinators, Program Area Team E Habilitation Plan Administrator, Psychology Associate, Attendant Counselor Manager Assistant Director and Director will be trained on Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement, for intake of new clients.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

3. The Program Area Team E Assistant Director or designee will review client #1’s updated IHP and will randomly attend 3 Individual Habilitation Plan’s for Hyak house for the next 12 months. For the next 12 months, the Program Area Team E Director or designee will review all short term or emergent stays to verify active treatment services.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Quality Assurance Incident Management Director, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

[Signature]
Title

[Signature]
Date

3/20/2020
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W198

Regulation: Clients who are admitted by the facility must be in need of and receiving active treatment services.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. While we don’t agree with these findings it was stated that client #11 was accepted to the facility for purpose other than for active treatment. The Interdisciplinary Team failed to follow 3.19 Admission Discharge Internal Client Movement by ensuring that client #11 had a developed Individual Habilitation Plan within 30 days of placement and providing active treatment during client #11’s stay.

2. Quality Assurance will update Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement to clarify the intake process regarding active treatment services. The Placement coordinators, Program Area Team E Habilitation Plan Administrator, Psychology Associate, Attendant Counselor Manager Assistant Director and Director will be trained on Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement, for intake of new clients.

3. For the next 12 months, the Program Area Team E Director or designee will review all short term or emergent stays to verify active treatment services.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, Program Area Team E Director, and Superintendent or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

[Signature]

Title: Supt.  
Date: 4/30/2020
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W206

Regulation: Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:

(I) Identifying the client’s needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and
(II) Designing programs that meet the client’s needs.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Habilitation Plan Administrator for client #1 failed to ensure assessments were accurate, prioritized, and individualized specific to client #1. This lead to client #1 not receiving a program of specialized training to help him learn to be more independent, and prolonged his time at the facility. The Interdisciplinary Team did not collaborate to develop a program based on client #1’s needs and then focus formal programming on those needs.

2. The Hyak Interdisciplinary Team will be trained on completing assessments and formally implementing them through the Individual Habilitation Plan by the Program Area Team E Assistant Director or designee. The Attendant Counselor Manager will complete a new Attendant Counselor assessment on client #1. The Habilitation Plan Administrator will review client #1’s Attendant Counselor assessment along with the Interdisciplinary Team and determine prioritized needs for client #1. The Individual Habilitation Plan will revise the Individual Habilitation Plan for client #1. The Psychology Associate will update the Positive Behavioral Support Plan and Psychological Assessment for client #1 to address any training needs. The Program Area Team E Assistant Director will review all new assessments and plans developed for client #1 to ensure a focused individualized program plan has been developed. The Interdisciplinary Team will train Hyak Direct Care Staff on any changes in the Individual Habilitation Plan, Positive Behavioral Support Plan and formal programs. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken.

3. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development.

4. The Program Area Team E Assistant Director or designee will review client #1’s updated IHP and will randomly attend 3 Individual Habilitation Plan’s for Hyak house for the next 12 months. The Program Area Team E task force will review all of Hyak’s current Habilitation Plans.

The plan of correction will be fully implemented no later than March 23rd, 2020.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

5. The Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W214

Regulation: The comprehensive functional assessment must identify the client’s specific developmental and behavioral management needs.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Psychology Associate failed to follow Standard Operating Procedure 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans to have a plan to reduce the restriction of a locked closet for client #7 because he was peeing and pooping (tracked as defecation in Positive Behavioral Support Plan) in his room, and soiling his belongings. This failure prevented him from learning appropriate ways to communicate and resulted in his closet remaining locked, denying him free access to his personal belongings. There were no training plans for the client to learn that peeing or pooping in his room was inappropriate and if he discontinued the behavior, his closet would be unlocked. The Positive Behavioral Support Plan did not include an adaptive replacement behavior training for how client #7 would learn to discontinue the inappropriate behaviors in order to gain free access to his belonging. The functional assessment did not identify an adaptive replacement behavior associated with the function of defecating and urinating. The lack of communication amongst the Hyak Interdisciplinary Team led to the breakdown between the client’s treatment plans. The Habilitation Plan Administrator failed to provide oversight of the Individual Habilitation Plan. This failure resulted lack of replacement behavior training to reduce the need for a restriction.

2. The Hyak Interdisciplinary Team will be trained on Standard Operating Procedure 3.06 Positive Behavior Support Plans, 3.12 Use of Protective Restrictive Procedures and Developmental Disabilities Administration Policies 5.14 Positive Behavior Support Principles and 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and the Psychological Assessment for client #7. The Psychology Associate will train Hyak staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior to specifically address the reduction of the locked closet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development to improve team work and communication.

3. Psychology monthly reviews will be revised to a standard format to include a section to monitor reduction plans for restrictive procedures. The review template will include clear instructions on how to complete each section of the Psychology monthly review. The Director of
Plan of Correction for Statement of Deficiency

Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Programs or designee will take a random samples of 16 Program Area Team E client reviews (2 per living unit) per quarter for 12 months to ensure this is being completed. Quality Assurance will review a random sample of 16 Program Area Team E client reviews (2 per living unit) per quarter for 12 months to monitor reduction plans for restrictive procedures, to ensure adaptive replacement programs are in place. Results of this sample will be sent to the Interdisciplinary Team for review and any needed follow up.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, Staff Development, and Director of Programs or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

 Title

 Signature

 Date

3/30/2020
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W220

Regulation: The comprehensive functional assessment must include speech and language development.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Habilitation Plan Administrator for client #1 failed to ensure assessments were accurate and individualized specific to client #1. The Interdisciplinary Team did not collaborate to develop programming based on client #1’s needs and then focus formal programming on those needs. The Interdisciplinary Team failed to ensure that an assessment was completed discussing barriers of communication and alternative means of communication. The assessment also failed to have recommendation(s) for receptive or expressive communication. This failure provided a viable way for client #1 to communicate his wants and needs to Direct Care Staff other than resorting to self-injurious behavior or aggressive behaviors.

2. The Speech Language Pathologist will be trained on completing thorough communication assessments and formally implementing them through the Individual Habilitation Plan by the Director of Programs or designee. The Speech Language Therapist will complete a new communication assessment on client #1, with oversight from the Therapies supervisor. The communication assessment will include recommendations for barriers of communication and alternative means of communication. The communication assessment will also include recommendation(s) for any need in receptive or expressive communication. The Habilitation Plan Administrator will review client #1’s communication assessment along with the Interdisciplinary Team, which is to include the Speech Language Pathologist and determine prioritized needs specific for client #1. The Habilitation Plan Administrator will revise the Individual Habilitation Plan for client #1. The Psychology Associate will update the Positive Behavioral Support Plan and Psychological Assessment for client #1 to address any communication training needs based on the updated communication assessment. The Program Area Team E Assistant Director will review all the new assessments, plans and the new Individual Habilitation Plan developed for client #1 to ensure a focused individualized program plan has been developed. The Interdisciplinary Team will train Hyak Direct Care Staff on any changes in the Individual Habilitation Plan, Positive Behavioral Support Plan and formal communication programs. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development. The Program Area Team E task force will develop a tool which includes guidance on what is needed to complete a thorough and accurate assessment.

3. The Director of Programs or designee will review 100% of all Program Area Team E communication assessment completed by the Speech Language Pathologist for 30 days. All
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

corgeous or issues will be addressed between the Speech Language Pathologist and the Director of Programs or designee and corrected prior to submitting the completed communication assessment. The Program Area Team E Assistant Director or designee will review all new annual Individual Habilitation Plan documents for all Hyak clients to ensure a focused individualized program plan has been developed within the Individual Habilitation Plan for the next 12 months. The Director of Programs will train all disciplines on the new tool which includes guidance on what is needed to complete a thorough and accurate assessment.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Director of Programs, Program Area Team E Director, and Staff Development or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

[Signatures]

Title

Signature

Date
Plan of Correction for Statement of Deficiency

Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Tag Number W226

Regulation: Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. While we don’t agree it was stated that client #11 was accepted to the Facility for purpose other than for active treatment. The Interdisciplinary Team failed to follow 3.19 Admission Discharge Internal Client Movement by ensuring that client #11 had a developed Individual Habilitation Plan within 30 days of placement and providing active treatment during client #11 stay.

2. Quality assurance will update Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement to clarify the intake process regarding active treatment services. The Placement Coordinator Department, Program all Area Team E Habilitation Plan Administrators, Psychology Associates, Attendant Counselor Managers, Assistant Director and Director will be trained on the updated Standard Operating Procedure 3.19 Admission Discharge Internal Client Movement.

3. Program Area Team E Director or designee will review all short term or emergent stays to verify active treatment services for 12 months.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

[Signature]
Title

3/30/2020
Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W234

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

1. Program Area Team E completed a root cause analysis of the occurrence leading to the citation. The facility failed to ensure that teaching plans contained clear and detailed instructions for staff for client #4, which resulted in staff not knowing how to teach client #4. The Habilitation Plan Administrator failed to accurately review teaching plans for client #4, leading to program plans written by Attendant Counselor Manager and Adult Training Specialist II not containing clear and detailed instructions for staff to implement them correctly and consistently.

2. The Shasta Interdisciplinary Team and the Adult Training Specialist II will be trained on program plan writing and implementation by Staff Development or designee. The Shasta Interdisciplinary Team including Adult Training Program will review and revise all teaching plans for client #4, ensuring that programs have clear and detailed instruction for staff implementation. The Adult Training Specialist III’s will review initially 100% of current PAT E training programs. A random sample of 3 client’s teaching plans from Shasta will be reviewed at the next Program Area Team E Taskforce. The Interdisciplinary Teams and Adult Training Specialists will be informed of any revisions or follow-up needed.

3. Adult Training Specialist II’s will submit to their Adult Training Specialist III’s copies of their Monthly Program Reviews along with copies of the client’s current program data sheets. The Monthly Program Reviews and copies of the current program data sheets will also be submitted to the Habilitation Plan Administrator for review. On a quarterly basis, the Program Area Team E Taskforce will review a random sample of 9 Program Area Team E client’s teaching plans. This review will include adaptive replacement, self-administration of medication, and Adult Training Program programs to make certain clear and detailed instructions for staff to implement correctly and consistently.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Adult Training Program Supervisor, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W242

Regulation: The individual program plan must include, for those clients who lack them, training in personal skill essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrate that the client is developmentally incapable of acquiring them.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Habilitation Plan Administrator for client #1 failed to ensure assessments were accurate and individualized specific to client #1 to gain greater independence in grooming and communication of his basic needs. The Interdisciplinary Team did not collaborate to develop programs based on client #1’s needs and then focus formal programming on those needs.

2. The Program Area Team E Director or designee will train the Hyak Interdisciplinary Team on completing assessments accurately and formally implementing them through the Individual Habilitation Plan. The Attendant Counselor Manager will complete a new Attendant Counselor assessment on client #1. The Psychology Associate will update the Positive Behavioral Support Plan and Psychological Assessment for client #1 to address any training needs. The Habilitation Plan Administrator will review all of client #1’s assessments. The Interdisciplinary Team will determine prioritized needs for client #1. The Habilitation Plan Administrator will develop a new Individual Habilitation Plan for client #1 based on the updated assessments. The Program Area Team E Assistant Director or designee will review all new assessments and plans developed for client #1 to ensure a focused individualized program plan has been developed. The Interdisciplinary Team will train Hyak Direct Care Staff on any changes in the Individual Habilitation Plan, Positive Behavioral Support Plan and formal programs. The Hyak Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development.

3. For the next 12 months, the Program Area Team E Assistant Director or designee will review all of this Habilitation Plan Administrator’s Individual Habilitation Plans, including client #1’s updated Individual Habilitation Plan. The Program Area Team E Assistant Director or designee will randomly attend 3 Individual Habilitation Plan’s for Hyak house.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Program Area Team E Director, and Staff Development or designee(s) shall be responsible for the implementation of the acceptable plan of correction.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E:
Date of SOD: 02/07/2020
Event ID# CSLM11

[Signature and Date]
Title

[Signature]
Date

This document was prepared by Residential Care Services for the Locator website.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Tag Number W247

Regulation: The individual program plan must include opportunities for client choice and self-management.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. We do not agree with this citation based on our assessment that client #7's food was in fact altered to the recommended diet texture. Review of the Rainier School Menu Book showed the menu for January 30, 2020 (week 6 dinner) that cake for ground texture was to be mashed. This was determined to be an error on the type of texture needed for cake for January 30, 2020 dinner. The Rainier School Menu Book should state per Standard Operating Procedure 4.07 Diet Modification, soaked & cut into ¼" pieces.

2. The Dietician will review the entire the Rainier School Menu Book to ensure all diet textures are accurate per Standard Operating Procedure 4.07 Diet Modification.

3. The Food Service Manager will monitor the Rainier School Menu Book quarterly to ensure it is accurate per Standard Operating Procedure 4.07 Diet Modification.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Food Service Manager or designee shall be responsible for the implementation of the acceptable plan of correction.

[Signatures and dates]
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W252

Regulation: Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. For client #4, the Adult Training Specialist II failed to ensure that data was taken per the program criteria, and the Adult Training Specialist III failed to have oversight to ensure the formal program was to be run per the criteria as documented in program data sheet. For client #5, the Direct Care Staff failed to ensure that data was taken per the program criteria and the Attendant Counselor Manager failed to have oversight to ensure the formal program was to be run per the criteria as documented in the program data sheet. The Habilitation Plan Administrator's for client #4 and client #5 failed to maintain oversight to ensure program data was taken per Individual Habilitation Plan criteria. These failures caused the individualized program plan objectives to not be documented in measurable terms.

2. The Adult Training Specialist for client #4 will be trained on documenting program data as instructed in the program data sheet. The Adult Training Specialist Supervisor or designee for client #4 will be trained on how to properly monitor that consistent documentation is being taken per the program data sheet. The Adult Training Specialist III's will review initially 100% of all current PAT E training programs. The Direct Care Staff for client #5 will be trained on documenting program data as instructed in the program data sheet. The Attendant Counselor Manager for client #5 will be trained on how to properly monitor that consistent documentation is being taken per the program data sheet. The Habilitation Plan Administrator's for client #4 and client #5 will be trained on how to ensure that consistent data is taken per the program plan based on the Individual Habilitation Plan.

3. Adult Training Specialist II's will submit to their Adult Training Specialist III's copies of their Monthly Program Reviews along with copies of the client's current program data sheets. This will include the Adult Training Specialist III to review 100% of all program plans and data sheets to ensure all have been corrected. The Monthly Program Reviews and copies of the current program data sheets will also be submitted to the Habilitation Plan Administrator for review. On a quarterly basis, the Program Area Team E Taskforce will review a random sample of 9 Program Area Team E client's teaching plans. This review will include adaptive replacement, self-administration of medication, and Adult Training Program programs to make certain clear and detailed instructions for staff to implement correctly and consistently.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Adult Training Program Supervisor, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

SIGNED: [Signature]

[Date: 3/30/2020]
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

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Plan of Correction for Statement of Deficiency

Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W255

Regulation: 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 clients has successfully completed an objective or objectives identified in the individual program plan.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Habilitation Plan Administrator failed to monitor client #5’s formal program and revise or discontinue the program as necessary when the criteria was met. This failure led to possible delay in client #5’s learning progress and the opportunity to learn new skills.

2. The Habilitation Plan Administrator and Attendant Counselor Manager will review client #5’s program 1140.4 to revise or discontinue as warranted by current skill level. The Habilitation Plan Administrator will submit the Individual Habilitation Revision and the program data sheet to the Program Area Team E Assistant Director for review to ensure it includes the reason for the program revision. The Alpine Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy.

3. Quality Assurance will review all of client #5’s formal programs to meet regulatory guidelines. Quality Assurance will review a random sample of 12 clients (2 per house) formal programs to meet regulatory guidelines per quarter for a period of 12 months.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and Program Area Team E Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W260

Regulation: At least annually the individual program plan must be revised as appropriate repeating the process set forth in paragraph (c) of this section.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Psychology Associate failed to follow Standard Operating Procedure 3.06 Positive Behavior Support Plans and Developmental Disabilities Administration Policy 5.21 Functional Assessments and Positive Behavior Support Plans to update the Positive Behavioral Support Plan and Psychological Assessment for a newly identified self-injurious behavior for client #1. The lack of communication among the Hyak Interdisciplinary Team led to the breakdown between the client's treatment plans. The Habilitation Plan Administrator failed to provide oversight of the Individual Habilitation Plan. This failure resulted in inaccurate information in the treatment plan, lack of prevention, monitoring and replacement behavior training for self-injurious behavior that resulted in harm for client #1.

The Dentist did not update the dental assessment for client #5. This is a repeat citation from the Standard of Deficiency dated 05/15/2019 Event ID# KTEI1. This resulted in the Individual Habilitation Plan containing inaccurate information based on the dental assessment.

2. The Hyak Psychology Associate and Habilitation Plan Administrator will be trained on Standard Operating Procedure 3.06 Positive Behavior Support Plans and Developmental Disabilities Administration policy 5.21 Functional Assessments and Positive Behavior Support Plans. The Psychology Associate will revise the Positive Behavioral Support Plan and the Psychological Assessment for client #1. The Psychology Associate will train staff to implement the updated Positive Behavioral Support Plan to include the adaptive replacement behavior and daily behavior tracking sheet. The Habilitation Plan Administrator will update the Individual Habilitation Plan to include the changes in the Positive Behavioral Support Plan and the Psychological Assessment. The Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development.

The dentist will update his assessment to note client #5’s current dental health. The Dental office will review all Program Area Team E dental assessments and update as needed to ensure all Program Area Team E clients’ dental health is current and accurate. The Dentist will ensure the Interdisciplinary Teams are provided with any dental assessments that have been modified. The Superintendent or designee will review the Dentist’s performance and act accordingly based on their review.
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

3. Psychology monthly reviews will be revised to include a section for potential new challenging behaviors. The review template will include clear instructions on how to complete each section of the Psychology monthly review. On a quarterly basis, the Director of Programs or designee will take a random sample of 16 psychology monthly reviews to ensure this was completed. Standardized house team forms will be developed that will identify potential new challenging behaviors.

On a quarterly basis, Quality Assurance will review a random sample of 16 Program Area Team E clients (2 per living unit) dental assessments to ensure they are current and accurate. Results of this sample will be sent to the Interdisciplinary Team for review and any needed follow up.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, Director of Programs, Superintendent, Program Area Team E Director, and Staff Development or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title  Signature  Date

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Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W356

Regulation: The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. It was determined that Staff U failed to follow up in a reasonable amount of time to the appointment on 1/08/2018 after assessing a dental issue for client #6. Staff M failed to follow Standard Operating Procedure 4.03 Community Medical Care and document information she received from St. Elizabeth’s Hospital via a phone conversation regarding the teeth extraction for client #6. This failure resulted in not having a plan of care regarding mouth related care for client #6 for the removal of two teeth to ensure proper healing.

2. The Dentist will update his assessment to note client #6’s current dental health. The Dental Department will review all Program Area Team E dental assessments, update and address any urgent dental needs for all Program Area Team E clients. The Dentist will ensure the Interdisciplinary Teams are provided with any assessments that have been modified. The Superintendent or designee will review the Dentist’s performance and act accordingly based on their review. Staff M will be trained on Standard Operating Procedure 4.03 Community Medical Care to ensure all concerns are addressed including documentation and aftercare.

3. On a quarterly basis, Quality Assurance will review a random sample of 16 Program Area Team E clients (2 per living unit) dental assessments to ensure they are current, accurate and that any urgent dental needs are being addressed. Results of this sample will be sent to the Interdisciplinary Team and Superintendent for review and any needed follow up.

Upon return from a hospital, the Rainier School Intake Physician will address and document all concerns when any Program Area Team E client returns to address a care plan. For the next 60 days, the Superintendent will review all intake documents to ensure that post care plans are developed to address all medical needs.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and Superintendent or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W358

Regulation: If the facility maintains an in-home dental service, the facility must keep a dental summary maintained in the client’s living unit.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Dentist did not update the dental assessment for client #5. This is a repeat citation from the Standard of Deficiency dated 05/15/2019 Event ID# KTE11. This resulted in the failure of the Direct Care Staff having accurate information to appropriately care for client #5’s dental needs.

2. The Dentist will update his assessment to note client #5’s current dental health. The Dental Department will ensure the most current dental assessment is in client #5’s Health Interdisciplinary File. The Superintendent or designee will review the Dentist’s performance and act accordingly based on their review.

3. On a quarterly basis, Quality Assurance will review a random sample of 16 Program Area Team E clients (2 per living unit) dental assessments to ensure they are current and accurate. Results of this sample will be sent to the Interdisciplinary Team for review and any needed follow up.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and Superintendent or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

Title

Signature

Date: 3/30/2020
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# C5LM11

Tag Number W436.

Regulation: The facility must furnish, maintain in good repair, and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The Hyak team failed to ensure formal training was provided for client #1 to meet the recommendations of the Ophthalmologist. This failure led to client #1 not having the opportunity to learn the skills needed in order to use and take care of his eyeglasses.

2. The Hyak Interdisciplinary Team will assess to determine if client #1 is wearing his eyeglasses full time as recommended by the Ophthalmologist. If a need is determined, they will create and implement a formal program on the use and care of eyeglasses. The Habilitation Plan Administrator will revise the Individual Habilitation Plan for client #1. The Program Area Team E Assistant Director will review the plan developed for client #1 to ensure a focused individualized program plan has been developed for eyeglass use. The Interdisciplinary Team will train Hyak Direct Care Staff on the new Individual Habilitation Plan. Attendant Counselor Managers or designee will review each client’s adaptive equipment. The Habilitation Plan Administrator and Attendant Counselor Manager will determine training needs based off current assessments.

3. The Program Area Team E Assistant Director or designee will train all Program Area Team E Habilitation Plan Administrator’s on the Developmental Disabilities Administration’s Residential Habilitation Center Standard Operating Procedure 103.1 Individual Habilitation Plan and Individual Habilitation Plan Instructions. The Hyak Habilitation Plan Administrator will attend the next scheduled Habilitation Plan Administrator academy. The Program Area Team E Assistant Director will continue to provide oversight to the Habilitation Plan Administrator to ensure the Individual Habilitation Plan documents on his assigned caseload are being completed accurately. Should issues of noncompliance of regulations continue, progressive disciplinary action will be taken. The Hyak Interdisciplinary Team will participate in a team building exercise provided by staff development. Each client’s adaptive equipment will be reviewed prior to their Individual Habilitation Plan to ensure it is included in the IHP.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The Program Area Team E Director or designee shall be responsible for the implementation of the acceptable plan of correction.

[Signatures]
Title
Signature
Date
Plan of Correction for Statement of Deficiency
Rainier School Program Area Team E
Date of SOD: 02/07/2020
Event ID# CSLM11

Tag Number W460

Regulation: Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

1. The Program Area Team E Taskforce completed a root cause analysis of the occurrence leading to the citation. The diet order was not specific to a time or meal, rather AM for prune juice and BID for the fiber. It was also determined that there was no documentation by staff that could identify if client #1 received his prune juice or added fiber. The Program Area Team E Taskforce does not agree with the statement that “...and potentially contributed to client #1 being chemically restrained...” However, the lack of documentation by the Direct Care Staff as to client #1 receiving his prune juice and added fiber per the Physician’s dietary order did not provide medical staff with accurate information to properly treat client #1’s constipation.

2. Attendant Counselor nursing orders have been updated for client #1 to include fiber and prune juice as ordered on the Physician’s dietary order. This Attendant Counselor nursing orders require staff to document when given. Program Area Team E clients will have Attendant Counselor nursing orders developed for anyone who has prune juice and fiber ordered on the physician’s dietary order.

3. Quality Assurance will review all nursing orders to ensure they are updated for all clients who have prune juice and fiber ordered on the physician’s dietary order.

The plan of correction will be fully implemented no later than March 23rd, 2020.

4. The facility Quality Assurance Incident Management Director, and Nursing Director or designee(s) shall be responsible for the implementation of the acceptable plan of correction.

[Signatures and dates]