

**Developmental Disabilities Administration**  
**040 - M2 - TA - ICF-IID HABILITATION REQUIREMENTS**

**Agency Submittal: 2015-17 Final 2017 Sup**

**Budget Period: 2015-17**

**SUMMARY**

Recently all three state-operated Residential Habilitation Centers (RHC) that offer Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services (Rainier, Fircrest, and Lakeland Village) failed surveys by the Centers for Medicare and Medicaid Services (CMS), in part because clients' Habilitation Plans have not been updated and followed as completely and timely as new enforcement standards require. There is a risk of losing \$67 million in federal match each year if the ICF/IID program fails CMS surveys. Currently there are 45 ICF/IID cottages with only 25 Habilitation Plan Administrator (HPA) positions. In order to meet CMS requirements, DDA requests 4.6 Habilitation Plan Administrator FTE and \$896,000 (\$448,000 GF-State) to phase in hiring of 20 additional HPA positions in fiscal year 2017.

**PROBLEM STATEMENT**

In Washington, there are four RHCs, offering skilled nursing facility services, ICF/IID, or both. Rainier in Buckley, Fircrest in Shoreline and Lakeland Village in Medical Lake are the three RHCs that provide ICF/IID. In the past, the RHC program, residents, and stakeholders, such as residents' family members and guardians have generally considered that the ICF/IID is the client's home – a facility focused on keeping them healthy and safe. However, in recent years, CMS has emphasized the "intermediate" aspect of institutional care. That is, it is the responsibility of the RHC not to house and protect people, but rather to be actively preparing them for leaving the RHC and integrating into the community.

This change in interpretation and emphasis by federal regulators is changing the culture and practices in the three ICF/IIDs. The staff has been trained and are being held accountable for engaging the residents in aggressive and continuous active treatment. An example of the difference between status quo care and active treatment to show habilitative supports is eating. If a client were unable to feed himself or herself, the prior plan would be for the staff to cut up their food and assist them with eating. However, to comply with the directive for continuous and aggressive active treatment, the proper approach is to work with the client to teach them to cut up their food into appropriate bite size pieces. Once that goal is accomplished, then move on to instruction on how to use utensils for eating. Each of these steps has to be incorporated into a plan, implemented, results documented, and the plan is continuously updated to reflect current progress and new goals.

Ensuring the habilitation plans are current, ensuring that they are being followed, and having current updates to the plans as progress being made has been a particular sticking point for the recent ICF certification surveys, with DSHS coming very close to losing tens of millions of dollars in annual federal matching funds for not meeting the revised interpretation of federal requirements around active treatment. It is not feasible for HPAs who write, help implement and oversee these plans for clients in multiple cottages to document and revise the habilitation plans. Typically, 16 individuals reside in each cottage. None of the recent surveys at Lakeland, Fircrest or Rainier (Pat A, PAT C and most recently at PAT E) were passed initially. All three ICF/IIDs were under stop placement orders for months that did not allow any new clients to be admitted until deficiencies were resolved. The resulting effort to meet the requirements



**DSHS VISION**

People are healthy • People are safe • People are supported • Taxpayer resources are guarded

**DSHS MISSION**

To transform lives

**DSHS VALUES**

Honesty and Integrity • Pursuit of Excellence • Open Communication • Diversity and Inclusion • Commitment to Service

**040 - M2 - TA - ICF-IID Habilitation Requirements**

took an unusual amount of overtime, and even travel as subject matter expert teams came from across the State to assist with meeting and documenting compliance standards for active treatment.

**PROPOSED SOLUTION**

Adding 20 new Habilitation Plan Administrators (HPA) in order to have one in each cottage is necessary to ensure that the ICF/IIDs update habilitation plans completely and timely, a key requirement to retain the ability to admit new clients and continue to receive federal matching funds.

**EXPECTED RESULTS**

With a Habilitation Plan Administrator in each ICF/IID cottage, DDA will be ready to pass federal inspections, provide the continuous and aggressive active treatment that will allow RHC residents to transition out of the temporary placement into a community setting faster, and tens of millions of dollars of federal match will continue to help fund the RHC operations each year.

**STAKEHOLDER IMPACT**

Several stakeholders will welcome the additional emphasis on compliance with continuous and aggressive active treatment in accordance with federal regulations, including CMS and Disability Rights Washington (DRW).

There may also be some resistance from RHC resident stakeholder groups such as Friends of Fircrest, Friends of Rainier, and Friends of Lakeland Village. Many family members and guardians have viewed the RHCs as a place where people are healthy and safe, not where they are pushed every day to achieve more functional abilities in order to transition out of the RHC.

Agency Contact: Bryan Way, (360) 902-7769

Program Contact: Don Clintsman, (360) 725-3421

OTHER CONNECTIONS

Performance Outcomes/Important Connections

**1. Does this DP provide essential support to one or more of the Governor's Results Washington priorities?**

Goal 4: Healthy & Safe Communities - Healthy People - Provide access to good medical care to improve people's lives.

**2. The decision package meets the following DSHS' strategic objectives:**

2.2: Increase opportunities for individuals who live in large residential facilities to have the option to move into the community and be supported as needed.

1.2: Increase the effectiveness and meaningfulness of client's activities, routines and choices to support individuals to become more actively engaged in learning and developing skills that lead to greater independence.

**3. Identify other important connections or impacts below.** (Indicate 'Yes' or 'No'. If 'Yes' identify the connections or impacts related to the proposal.)

- a) Regional/County impacts? No
- b) Other local government impacts? No
- c) Tribal government impacts? No
- d) Other state agency impacts? No
- e) Responds to specific task force, report, mandate or executive order? Yes
- f) Does request contain a compensation change or require changes to a Collective Bargaining Agreement? No
- g) Facility/workplace needs or impacts? No
- h) Capital budget impacts? No
- i) Is change required to existing statutes, rules or contracts? No
- j) Is the request related to litigation? No
- k) Is the request related to Puget Sound recovery? No
- l) Other important connections? No

**4. Please provide a detailed discussion of connections/impacts identified above.**

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There have been numerous reports from CMS citing deficiencies in the level and type of active treatment provided in the three ICF/IIDs, including the most recent failed survey of Pat E at Rainier School in September 2016.

**Alternatives/Consequences/Other**

**5. What alternatives were explored by the agency, and why was this alternative chosen?**

The alternative is to try to continue to use only existing staff to write the new plans with higher active treatment goals, implement the plans, and then document and update those plans in a timely manner. This was an all-out effort by dozens of classified RHC staff and management to meet the corrective action plans imposed by CMS. The plan of continuing to use overtime and have people travel to different parts of the state for every survey is not a sustainable model.

**6. How has or can the agency address the issue or need within its current appropriation level?**

See the answer to #5 above. It is not a feasible option to continue to ensure federal compliance without enough people to the required work on an ongoing daily basis.

**7. Does this decision package include funding for any IT-related costs (hardware, software, services, cloud-based services, contracts or IT staff)?**

**No**

**Yes (Include an IT Addendum)**

**Fiscal Detail****040 - M2 - TA - ICF/IID Habilitation Requirements**

<b>Operating Expenditures</b>	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>
001-1 General Fund-State	0	448,000	941,000	941,000
001-7 General Fund-Priv-Loc	0	54,000	141,000	141,000
001-C General Fund-Medicaid	0	394,000	1,019,000	1,019,000
<b>Total Cost</b>	<b>0</b>	<b>896,000</b>	<b>2,101,000</b>	<b>2,101,000</b>

<b>Staffing</b>	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>
FTEs	0.0	9.2	20.0	20.0

**Performance Measure Detail**

<b>Activity:</b>	<b>Incremental Changes</b>			
	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>
<b>Program: 040</b>				
D086 Residential Habilitation Facilities	0	0	0	0
No measures submitted for package				

**Object Detail**

	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>
A Salaries and Wages	0	571,000	1,272,000	1,272,000
B Employee Benefits	0	231,000	622,000	622,000
E Goods and Other Services	0	59,000	129,000	129,000
G Travel	0	4,000	8,000	8,000
P Debt Service	0	3,000	6,000	6,000
TZ Intra-agency Reimbursements	0	28,000	64,000	64,000
<b>Total Objects</b>	<b>0</b>	<b>896,000</b>	<b>2,101,000</b>	<b>2,101,000</b>

**DSHS Source Detail****Overall Funding**

<b>Operating Expenditures</b>	<b><u>FY 2016</u></b>	<b><u>FY 2017</u></b>	<b><u>FY 2018</u></b>	<b><u>FY 2019</u></b>
<b>Fund 001-1, General Fund-State</b>				
<b><u>Sources Title</u></b>				
0011 General Fund State	0	448,000	941,000	941,000
<b>Total for Fund 001-1</b>	<b>0</b>	<b>448,000</b>	<b>941,000</b>	<b>941,000</b>
<b>Fund 001-7, General Fund-Priv-Loc</b>				
<b><u>Sources Title</u></b>				
5417 Contributions & Grants	0	54,000	141,000	141,000
<b>Total for Fund 001-7</b>	<b>0</b>	<b>54,000</b>	<b>141,000</b>	<b>141,000</b>
<b>Fund 001-C, General Fund-Medicaid</b>				
<b><u>Sources Title</u></b>				
19TA Title XIX Assistance (FMAP)	0	0	1,019,000	1,019,000
19UL Title XIX Admin (50%)	0	394,000	0	0
<b>Total for Fund 001-C</b>	<b>0</b>	<b>394,000</b>	<b>1,019,000</b>	<b>1,019,000</b>
<b>Total Overall Funding</b>	<b>0</b>	<b>896,000</b>	<b>2,101,000</b>	<b>2,101,000</b>



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
Aging and Long-Term Support Administration  
Residential Care Services  
PO Box 45600, Olympia, WA 98504-5600

July 29, 2015

**By Facsimile and Certified Mail (7007 1490 0003 4202 0429)**

**Notice of the Denial of Payment for New Admissions Remedy – Please Read Carefully**

Jeff Flesner, Superintendent  
Fircrest School  
15230 15<sup>th</sup> Ave. NE  
Shoreline, WA 98155-7196

RE: Recertification Survey  
5/11/15 through 5/21/15

Denial of Payment Remedy

Dear Mr. Flesner:

The Division of Residential Care Services (RCS) of the Aging and Long-Term Support Administration (AL TSA) will be imposing Denial of Payment for New Admissions Sanction at Fircrest School PAT A ICF/IID. The reasons for this decision, the time frame for imposition of the remedy, and your appeal rights are described below.

From May 11, 2015 through May 21, 2015, survey staff from RCS conducted a survey at Fircrest School. Based on that survey, RCS determined that Fircrest School is out of compliance with three federal Conditions of Participation (CoPs) for facilities certified to provide Medicaid Title XIX ICF/IID services. Compliance with all Conditions of Participation (CoPs), found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The survey completed on May 21, 2015, found that Fircrest School failed to comply with the following CoPs:

- W102 – 42 CFR 483.410 Governing Body and Management
- W122 – 42 CFR 483.420 Client Protections
- W195 – 42 CFR 483.440 Active Treatment Services

The deficiencies are described in “Form CMS-2567”, a copy of which you received on June 5, 2015. The cited deficiencies indicate limitations in Fircrest School’s capacity to adequately

exercise operating direction over the facility and by failures to provide client protections and active treatment services. Significant corrections will be required before the facility can be found to be in compliance.

### **The Denial of Payment Remedy**

RCS has elected to impose the denial of payments for new admissions remedy.

This notice is being provided as required by 42 CFR 442.118 and SOM 3006, which requires notice to the facility of imposition of the denial of payment remedy if it will not be able to correct within 60 days following the last day of the survey. July 20, 2015 was the 60<sup>th</sup> day following the survey. Your appeal rights and the time frame for implementation of the denial of payments are described in the following paragraphs.

Denial of payment for new admissions is an alternative to termination from the Medicaid Title XIX ICF/IID program. (Under the termination remedy, RCS would have to terminate Fircrest School ICF/IID from the Medicaid program if it did not achieve substantial compliance with federal requirements by August 19, 2015 (42 CFR 442.101 (3) (e); SOM 3005 E; SOM 3012). If RCS determines that Fircrest School ICF/IID is in substantial compliance with the CoPs before the denial of payment for new admissions takes effect, then the remedy will not be implemented.

### **Appeal Rights**

Prior to implementation of the denial of payment for new admissions remedy, you have the right to request an informal hearing before an official who was not involved in making the initial determination (42 CFR 442.118). During the informal hearing you may present evidence or documentation in writing or in person to refute the determination that the facility is out of compliance with the CoPs. A request for the informal hearing must be received on or before August 12, 2015.

If an informal hearing is not requested within ten working days, the denial of payment remedy will take effect immediately. If you request a hearing, and the hearing decision upholds RCS's findings of noncompliance with the conditions of participation, the remedy will be implemented after the facility and the public has been provided 15 days notice of the imposition of the remedy.

Once implemented, the denial of payment remedy will continue in effect for eleven (11) months unless RCS finds that: 1) the deficiencies have been corrected, 2) Fircrest School ICF/IID is making a good faith effort to achieve compliance, or 3) the deficiencies make it necessary to terminate the facility.

You may request an informal hearing by sending a written request to:

Kathy Morgan  
Director, Residential Care Services  
P.O. Box 45600  
Olympia, WA 98504-5600

The request should identify the issues you plan to raise during the hearing.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2484.

Sincerely,



Gerald Heilinger, Field Manager  
ICF/IID Survey and Certification Program  
Residential Care Services

cc: CMS Regional Office, Washington State ICF/IID Team  
Bill Moss, Assistant Secretary of AL TSA  
Kathy Morgan, Director of RCS  
Loida Baniqued, RCS HQ Operations Chief  
Angela Coats-McCarthy, Assistant Attorney General  
Evelyn Perez, Assistant Secretary of DDA  
Donald Clintsman, Deputy Assistant Secretary of DDA  
Janet Adams, DDA Office Chief  
Larita Paulsen, DDA QM Unit Manager  
Bruce Work, Medicaid Compliance Administrator  
Kari Mohr, Health Care Authority

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey & Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

**RECEIVED**

NOV - 3 2014

Superintendent's Office  
Lakeland Village

October 31, 2014

James Ward Tappero, Administrator  
Lakeland Village Nursing Facility  
State Highway 902 & Salnave Road  
Medical Lake, WA 99022

**CMS Certification Number: 50-A263**

**RE: Discretionary Denial of Payment  
Intent to Impose Civil Money Penalty**

Dear Mr. Tappero:

On September 19, 2014, a Federal Monitoring survey was completed at Lakeland Village Nursing Facility by the Centers for Medicare & Medicaid Services (CMS) to determine if the facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. The State survey agency found and notified you that the most serious deficiency was isolated in nature and constituted actual harm that is not immediate jeopardy (Scope/Severity = G) to resident health and safety. The results of the surveys were listed on the Statement of Deficiencies and Plan of Correction (Form CMS-2567) and sent to you.

We agree that the following requirements were not met and that this constitutes substantial noncompliance and actual harm to residents:

42 CFR § 483.10	Resident Rights
42 CFR § 483.13	Resident Behavior and Facility Practices
42 CFR § 483.15	Quality of Life
42 CFR § 483.25	Quality of care (Actual Harm)
42 CFR § 483.45	Specialized Rehabilitative Services
42 CFR § 483.75	Administration

### **Discretionary Denial of Payment for New Admissions**

Because Lakeland Village Nursing Facility was not in substantial compliance with health requirements, we are imposing a discretionary denial of payment in accordance with the following:

**Denial of Payments for New Medicare and Medicaid Admissions, as authorized by the Social Security Act, Section 1819(h)(2)(B) (i) and Section 1919(h)(2)(A) (i), and implemented at 42 CFR § 488.417(a).**

This is effective for new Medicare and Medicaid admissions if the facility is not in substantial compliance on or after **November 15, 2014**. This denial of payment for new admissions also applies to Medicare and Medicaid patients who are members of managed care plans. If Lakeland Village Nursing Facility remains out of substantial compliance, its Medicare provider agreement will be terminated no later than March 19, 2015.

### **Appeal Rights**

If you disagree with these determinations, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services' Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Chief, Civil Remedies Division  
Departmental Appeals Board MS 6132  
Cohen Building, Room 637-D  
330 Independence Avenue, SW  
Washington, D.C. 20201

**Please also send a copy to:** Chief Counsel  
Office of General Counsel, DHHS  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104

A request for a hearing must contain the information specified in 42 CFR § 498.40(b) and must identify the specific issues, the findings of fact and the conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

### **Intent to Impose a Civil Money Penalty**

Because of the nature of the Actual Harm findings, it is also our intent to impose a “per instance” **civil money penalty (CMP)** against Lakeland Village Nursing Facility in the amount of \$2,000.00 for the G level citations found at 42 CFR 483.25 (Tag F314). If we decide to impose a CMP, our office will send you a letter that: 1) imposes a CMP; 2) notifies you of your Independent Informal Dispute Resolution rights and; 3) notifies you of your appeal rights. **Do not send payment at this time.**

Before making a final decision on the amount of a civil money penalty, we are required to consider the facility's financial condition (42 CFR § 488.438(f)). If there is any financial information you feel should be included in this process, please submit it to us by **November 14, 2014**. This information is not limited to, but should include the following:

1. The facility's year-to-date financial statements (including profit and loss statement and balance sheet). If possible, this information should be audited or certified.
2. The facility's audited financial statements from the past year complete with all attachments and audit notes.
3. The facility's current year cash flow projections with year-to-date actuals.
4. The facility's signed federal tax return from the past year.

If you have any questions, please contact Gary Keopanya of my staff at (206) 615-2321 or by email at [gary.keopanya@cms.hhs.gov](mailto:gary.keopanya@cms.hhs.gov).

Sincerely,



Patrick Thrift, Manager  
Survey, Certification & Enforcement Branch

cc: ADSA – Bett Schlemmer  
ADSA – Linda Ronco  
ADSA – Susan Worthington  
District 1 – Lori Heiner  
HRSA – Chau Nguyen  
Washington State Ombudsman





STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
ALTSA, RCS, ICF/IID Survey & Certification Program  
PO Box 45600, Olympia, WA 98504-5600

April 22, 2016

**E-MAIL and CERTIFIED MAIL (7007 1490 0003 4195 0765)**

Important Notice – Please Read Carefully

Harvey Perez, Superintendent  
Rainier School PAT A  
PO Box 600  
Buckley, Washington 98321

RE: Credible Allegation Survey 4/4/2016 through 4/8/2016 related to the Annual  
Recertification Survey 3/2/2015 through 3/11/2015

Dear Mr. Perez:

Staff from Residential Care Services (RCS) Division of Aging and Long-Term Support  
Administration (ALTSA) conducted a Credible Allegation Survey from April 4, 2016 through  
April 8, 2016 at Rainier School PAT A.

Rainier School PAT A has been out of compliance with the following conditions of participation:

W102 - Governing Body  
W122 - Client Protections  
W195 – Active Treatment

As a result of being out of compliance with these conditions of participation, Rainier School  
PAT A has been denied payment since May 22, 2015. That denial of payment remedy will  
expire on April 22, 2016.

RCS acknowledges that Rainier School PAT A has made good faith efforts to achieve  
compliance with the conditions of participation. These efforts include: Changes in the  
implementation of restraint and restriction usage and documentation, a contracted training  
program, a quality assurance program, administration changes, and the recent implementation of  
active treatment trainers. These changes have resulted in Rainier School PAT A regaining  
compliance with the conditions of participation W102 - Governing Body and W122 - Client

Protections. However, those changes did not significantly impact the compliance issues identified with condition of participation W195 – Active Treatment.

The Credible Allegation Survey determined Rainier School PAT A remains out of compliance with condition of participation W195 – 42 CFR 483.440 regarding active treatment. In addition, PAT A was found out of compliance with other regulations as well. Compliance with all conditions of participation, found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for continuation in the Medicaid Title XIX ICF/IID program.

The compliance issues identified in the Credible Allegation Survey are described in the attached CMS Form 2567. These compliance issues include a description of the limited capacity to provide active treatment at Rainier School PAT A. Significant corrections will be required before Rainier School PAT A can be in compliance with this condition of participation.

### **Remedy**

Substantial compliance with federal requirements must be achieved and verified by July 7, 2016 (90 days from the date on which the survey was completed (SOM 3012)). Failure to achieve substantial compliance with 42 CFR 483.440, active treatment, may result in termination from the Medicaid ICF/IID program (42 CFR 442.101 (3) (e); SOM 3005 E).

RCS is not recommending termination from the Medicaid ICF/IID program at this time.

RCS will continue to assess Rainier School PAT A's efforts to gain compliance with active treatment. RCS believes the following areas should be addressed in any plan Rainier School PAT A develops to address the compliance issues. In the future, RCS will use these areas to assess Rainier School PAT A's good faith effort to regain compliance with this condition of participation:

- All staff understand the regulatory emphasis for training clients, what active treatment is and how to implement it
- Rainier School PAT A's resident assessments are current, accurate and identify all the needs of clients
- Individual Habilitation Plans (IHP) address core/pervasive needs of clients
- Training programs provide clear direction for staff and those directions are followed by all staff
- Data is collected and analyzed in a manner that directly relates to accomplishments of IHP objectives
- Rainier School PAT A employ a quality assurance measure that utilizes uninterrupted observation periods
- Utilize resources that meet the clients identified needs
- Rainier PAT A will develop systems that emphasize professional staff being actively engaged with Clients and Staff in the active treatment process

**Plan of Correction (PoC)**

Rainier School PAT A must submit a Plan of Correction for the following regulations which are not directly related to the condition of participation of active treatment:

W 125	CFR 483.420(a)(3)
W137	CFR 483.420(a)(12)
W287	CFR 483.450(b)(3)
W469	CFR 483.480(b)(1)(i)
W471	CFR 483.480(b)(1)(ii)

This Plan of Correction must be submitted within 10 calendar days of the receipt of this letter.

An acceptable Plan of Correction must contain, at a minimum, the following core elements (SOM 3006.5C):

1. How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice;
2. How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how it will act to protect individuals in similar situations;
3. What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;
4. How the facility will monitor corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and
5. When corrective action will be accomplished.

Additionally, we request that you include the title of the person responsible to ensure correction.

**Alternate Remedy**

In lieu of termination from the Medicaid program, the State Medicaid Agency (SMA) may choose to impose a Denial of Payments for New Admissions (42 CFR 442.118; SOM 3006). If the SMA chooses to impose the denial of payment remedy, you will be notified on or before the 60th day (June 7, 2016), and will be advised of any appeal rights at that time.

**Allegation of Compliance**

When you believe the condition of participation deficiencies have been corrected, please provide the ICF/IID Field Manager with a written credible allegation of compliance. The credible allegation should address all of the cited deficiencies associated with 42 CFR 483.440 - W195

Active Treatment. The letter should describe: (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur.

If Rainier School PAT A makes a credible allegation of compliance before July 7, 2016, the ICF/IID survey team will make only one revisit to determine whether compliance has been achieved. The compliance decision by RCS needs to be finalized no later than July 7, 2016 (90<sup>th</sup> day). RCS will require at least five working days to complete a credible allegation survey and make a decision regarding compliance. Please plan accordingly.

If upon a revisit based on your credible allegation of compliance, your facility has not achieved substantial compliance, termination or denial of payment for new admissions will be imposed. A revisit will not be conducted if a letter of credible allegation is not received by RCS. The condition of participation will need to be found to be in substantial compliance before certification can continue.

**Informal Dispute Resolution (IDR)**

You may request an IDR of the deficiencies on which this action is based. RCS must receive your request for an IDR no later than May 2, 2016. To request an informal dispute resolution (IDR) meeting, please send your written request to Informal Dispute Resolution Program Manager, PO Box 45600, Olympia, Washington 98504-5600. If you request an IDR, you must still submit a written credible allegation of compliance within the time limits described above. The written IDR request should:

- 1) Identify the specific deficiencies that are disputed;
- 2) Explain why you are disputing the deficiencies; and
- 3) Indicate the type of dispute resolution process you prefer (face-to-face, telephone conference or documentation review)

If requested, an IDR will be scheduled. During the informal process you have the right to present written and/or oral evidence refuting the deficiencies. The IDR process will not change the time frames stated in this letter, including the deadlines for achieving compliance and submitting a written credible allegation of compliance.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,



Gerald Heilinger, Field Manager  
ICF/IID Survey and Certification Program  
Division of Residential Care Services

Enclosure

cc: CMS Regional Office, Washington State ICF/IID Team  
Bill Moss, Assistant Secretary of AL TSA  
Candace Goering, Director of RCS  
Angela Coats McCarthy, AAG  
Evelyn Perez, Assistant Secretary of DDA  
Donald Clintsman, Deputy Assistant Secretary of DDA  
Marianne Lindeblad, Health Care Authority

**STATE OF WASHINGTON**  
**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**  
**Aging and Long-Term Support Administration**  
**Residential Care Services**  
PO Box 45600, Olympia, WA 98504-5600

February 11, 2016

**BY FACSIMILE and CERTIFIED MAIL 7007 1490 0003 4195 0581**

Important Notice – Please Read Carefully

Mr. Harvey Perez, Superintendent  
Rainier School – PAT C  
P. O. Box 600  
Buckley, WA 98321

RE: Annual Recertification Survey 11/16/2015 through 11/20/2016  
Revisit 1/11/2016 through 1/14/16 Immediate Jeopardy  
Revisit 2/4/2016 Confirmed Abatement of Immediate Jeopardy  
Denial of Payment

Dear Mr. Perez:

The Division of Residential Care Services (RCS) of the Aging and Long-Term Support Administration (AL TSA) will be denying payment for new admissions at Rainier School PAT C. The reasons for this decision, the time frame for imposition of the remedy, and your appeal rights are described below.

From 1/11/2016 through 1/14/2016 survey staff from the RCS/AL TSA conducted a revisit at your facility in response to your credible letter of allegation. Based on that revisit, RCS determined that Rainier School PAT C is still out of compliance with a federal requirement for ICFs/IID participating in the Medicaid Title XIX ICF/IID program. They also discovered noncompliance with standard W104 which posed an immediate jeopardy (IJ) to the health and safety of the residents at Rainier School PAT C. On 2/4/2016, survey staff conducted another onsite visit which confirmed the IJ was abated and compliance with W104 was achieved.

Compliance with all Conditions of Participation (CoP), found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The recertification survey completed on 1/14/2016, found that Rainier School PAT C failed to comply with the following CoP:

W195 – 42 CFR 483.440 Active Treatment Services.

The deficiencies are described in the Form CMS-2567, attached. The cited deficiencies indicate that Rainier School PAT C's capacity to provide adequate active treatment services is limited. Significant corrections will be required before the facility can be found in compliance.

### **Denial of Payment**

RCS has decided to deny Rainier School PAT C payment for new admissions.

This notice of intent to deny payment for new admissions is being provided as required by 42 CFR 442.118 and SOM 3006. Your appeal rights and the time frame for implementation of the denial of payments are described in the following paragraphs.

### **Appeal Rights**

Prior to the denial of payment for new admissions, you have the right to request an informal hearing before an official who was not involved in making the initial determination (42 CFR 442.118). During the informal hearing you may present evidence or documentation, in writing or in person, to refute the determination that the facility is out of compliance with the CoPs. A request for the informal hearing must be received on or before February 26, 2016.

If an informal hearing is not requested within ten working days, the denial of payment will take effect February 27, 2016. If you request an informal hearing, and the hearing decision upholds the findings of noncompliance with the CoPs, payment will be denied for new admissions after the facility and the public have had at least 15 days notice of the effective date of the denial of payment and the reasons for it.

Once implemented, the denial of payment remedy may continue in effect for eleven (11) months unless RCS finds that: 1) the deficiencies have been corrected, 2) Rainier School PAT C is making a good faith effort to achieve compliance, or 3) the deficiencies make it necessary to terminate the facility's certification.

You may request an informal hearing by sending a written request to:

Candace Goehring, Director  
Residential Care Services  
P.O. Box 45600  
Olympia, WA 98504-5600

The request should identify the issues you plan to raise during the hearing.

### **Plan of Correction (PoC)**

At this time Rainier School PAT C is required to submit a PoC for the following citations which were not included as part of the CoP for Active Treatment Services:

W125 – Protection of Client Rights

W149 – Staff treatment of Clients

W159 – QIDP

If you believe that any of the above referenced citations are significantly related to the Condition level citation and your corrections would be included in the Credible Allegation process, you may request, in writing, an extension of the submission of a PoC for that citation.

An acceptable PoC must contain, at minimum, the following core elements (SOM 3006.5):

1. How the corrective action will be accomplished for the sample individuals found to have been affected by the deficient practice;
2. How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how it will act to protect individuals in similar situations;
3. What measures will be put into place or systemic changes that will be made to ensure that the deficient practice will not recur;
4. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systematic change to ensure that solutions are permanent; and
5. When corrective action will be accomplished.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2484.

Sincerely,



Gerald Heiling, Field Manager  
ICF/IID Survey and Certification Program  
Division of Residential Care Services

Enclosure

Harvey Perez, Superintendent

February 11, 2016

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cc: CMS Regional Office, Washington State ICF/IID Team  
Bill Moss, Assistant Secretary of AL TSA  
Candace Goehring, Director of RCS  
Angela Coats McCarthy, Assistant Attorney General  
Evelyn Perez, Assistant Secretary of DDA  
Donald Clintsman, Deputy Assistant Secretary of DDA  
Janet Adams, DDA Office Chief  
Larita Paulsen, DDA QM Unit Manager  
Bruce Work, DDA Medicaid Compliance Administrator  
Marianne Lindeblad, Health Care Authority

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

PRINTED: 02/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD</b> <b>BUCKLEY, WA 98321</b>		
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{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>This report is a result of a Credible Allegation revisit Survey at Rainier PAT C on 1/11/16 to 1/14/16. The Department received a letter of Credible Allegations on 12/18/15. Failed provider practice was identified and an Immediate Jeopardy was cited at W104 due to the failure of the facility to ensure there was a comprehensive and effective system in place related to off-campus trips by Clients whereby management could ensure the Client ' s safety and the needs of the Clients were met by staff. Notification letters of Immediate Jeopardy with attached 2567 was sent on 1/19/16.</p> <p>On 2/04/16, State Surveyors revisited Rainier School PAT C and determined that a plan of correction related to the Immediate Jeopardy, identified during the Credible Allegation Survey at Rainier School PAT C on 1/11/16 to 1/14/16, had been implemented. The Facility developed an effective system to ensure Clients safety related to off campus trips and the Immediate Jeopardy cited at W104 is now abated. The 2567 was modified to reflcct the changes.</p> <p>The survey was conducted by:</p> <p>Jim Tarr Sarah Tunnell Justin Smith</p> <p>The survey team is from:</p> <p>State of Washington Department of Social and Health Services Residential Care Services Administration</p>	{W 000}			

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

TITLE

(X6) DATE

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

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{W 000}	Continued From page 1 ICF/IID Survey and Certification Program P.O. Box 45600 Olympia, WA 98504-5600 Office Phone: (360) 725-3215 FAX: (360) 725-2642	{W 000}		
{W 125}	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 5 Expanded Sample Clients (Client #11) had access to his personal clothing. His clothes were locked in a hall closet and he did not have a key. This failure prevented Client #11 from getting his personal clothing items independently.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Observation on 1/12/16 at 10:40 AM at 1040 Quinault Court (QC) revealed Client #11 ' s bedroom closet was empty. When asked where Client #11 ' s clothes were, Staff M showed the Surveyor a hallway closet which was locked and indicated Client #11 ' s clothes were in that closet. Staff M reported Client #11 did not have a key to unlock the closet.</p> <p>Record review on 1/13/16 at 9:20 AM of Client</p>	{W 125}		

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{W 125}	Continued From page 2 #11 ' s Individual Habilitation Plan (IHP) dated 7/16/15 and his Positive Behavioral Support Plan (PBSP) with an expiration date of 10/3/16 revealed a secured clothing closet was not indicated for Client #11.	{W 125}		
{W 149}	Interview on 1/14/16 at 10:00 AM with Staff K, E and F verified Client #11 ' s clothing should not be locked and that he should have access to his personal belongings. 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	{W 149}		
{W 159}	This STANDARD is not met as evidenced by: 483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the Qualified Intellectual Disability Professionals (QIDP) were completing paperwork in a timely manner, following the policies and procedures, ensuring Clients Individual Habilitation Plans (IHP) were implemented correctly and data was critically analyzed to measure progress for 6 of 10 Sample Clients (Clients #1, #2, #4, #5, #7 and #8) and 2 of 5 Expanded Sample Clients (Clients # 11 and #12). This failure prevented Clients from learning new skills, gaining independence and moving to a less restrictive setting.	{W 159}		

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{W 159}	<p>Continued From page 3</p> <p>This is repeat citation from the survey on 11/20/16.</p> <p>Findings include:</p> <p>Client #1: The QIDP failed to ensure current approvals for the use of psychotropic medications were in place from the Human Rights Committee (HRC) and consents from the Legal Guardian were in place. This failure resulted in the Client #1 receiving psychotropic medications that had not been approved by HRC and Legal Guardians. (See W262 and W263 for details.)</p> <p>Client #2: The QIDP failed to ensure Client #2 ' s IHP was implemented as written, Active Treatment Schedule was detailed enough to provide staff direction for his daily activities and accurately measure training objectives to measure progression. This failure prevented Client #2 from having structured training and from the facility determining whether he was learning, maintaining or showing regression in skills. (See W249, W250 and W252 for details.)</p> <p>Client #4: The QIDP failed to ensure Client #4 ' s IHP had objectives that described specific behaviors, training programs that provided instructions for staff to teach skills, training objectives that could accurately measure his success and current approvals for the use of psychotropic medications in place from HRC and consents from the Legal Guardian. This failure prevented Client #4 from</p>	{W 159}		

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{W 159}	<p>Continued From page 4</p> <p>having an IHP describing his specific needs, staff who could consistently provide training on his needs and he received psychotropic medications not approved by the HRC or Legal Guardians. (See W231, W234, W252, W262 and W263 for details.)</p> <p>Client #5: The QIDP failed to ensure Client #5 had an IHP objective written in singular terms and program instructions which provided enough instruction and information for staff to train him consistently over the course of the day. This failure put Client #5 at risk of not learning new skills which would allow him to be more independent. (See W229 and W234 for details.)</p> <p>Client #7: The QIDP failed to ensure Client #7 had his IHP modified when he showed regression in a training objective. This failure resulted in Client #7 continuing to work on a skill on which he was not making progress. (See W256 for details.)</p> <p>Client #8: The QIDP failed to ensure Client #8 had program instructions which provided enough instruction and information for staff to train him consistently over the course of the day, his IHP consistently implemented and to have training objectives which could be accurately measured to determine if he was learning skills. This failure prevented Client #8 from learning new skills and being accurately assessed to determine if/when he had achieved a new skill. (See W234, W249 and W252 for details.)</p>	{W 159}		

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{W 159}	Continued From page 5  Client #11: The QIDP failed to ensure Client #11 had basic needs identified, his IHP was implemented consistently and to have an IHP objective modified when he had passed criteria. This failure prevented Client #11 from receiving training on a basic need, receiving consistent program implementation and delayed his ability to learn new skills. (See W214, W249 and W255 for details.)  Client #12: The QIDP failed to ensure Client #12 had an updated Comprehensive Functional Assessment (CFA) following a significant medical event. This failure prevented Client #12 from learning new skills, maintaining skills, gaining independence and moving to a less restrictive setting. (See W259 for details.)	{W 159}			
{W 195}	483.440 ACTIVE TREATMENT SERVICES  The facility must ensure that specific active treatment services requirements are met.  This CONDITION is not met as evidenced by: Based on observations, record review and interviews the facility failed to develop systems for 6 of 10 Sample Clients (Clients #1, #2, #4, #5, #7 and #8) and 2 of 5 Expanded Sample Clients (Clients # 11 and #12) which ensured their training methods allowed the correct needs to be identified; the objectives were written in a way	{W 195}			

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{W 195}	<p>Continued From page 6</p> <p>which would allow success to be determined; training programs contained enough detail to ensure consistent implementation; the data being taken allowed measurement of the objective and the Qualified Intellectual Disabilities Professionals (QIDP) were monitoring and advocating for clients in a way which ensured they were progressing toward independence. This failure prevented Clients from learning new skills, maintaining skills, gaining independence and moving to a less restrictive setting.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the behavioral needs for Client #11 were identified and supports put in place to ensure his health and safety. This failure resulted in the Client crouching and eating on an unsanitary floor. (See W214 for details.)</li> <li>2. The facility failed to ensure Client #5 had an objective written in singular fashion, with only one discreet objective being trained and monitored. This failure of the facility to ensure objectives were written in a singular format prevented staff from determining which specific skills the Client was learning, maintaining or showing regression. (See W229 for details.)</li> <li>3. The facility failed to ensure Client #4 had terms to describe behaviors that could be changed or replaced. This failure resulted in the facility using a training objective which could not be quantified and the staff could not know what</li> </ol>	{W 195}		

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{W 195}	<p>Continued From page 7</p> <p>behavior to look for or whether the behavior was being expressed appropriately. This put the Client at risk of not learning new skills which would make him more independent. (See W231 for details.)</p> <p>4. The facility failed to ensure Clients #4, #5, and #8 had skill training programs which provided enough instruction and information for staff to train the Clients the same way over the course of the day. This failure put the Clients at risk of not learning new skills which would allow them to be more independent. (See W234 for details.)</p> <p>5. The facility failed to ensure Clients #2, and #8 and 1 of 5 Expanded Sample Clients (Client #11) had Individual Habilitation Plans (IHP) that was implemented as they were written. This failure prevented the Clients from receiving the training they needed to become more independent. (See W249 for details.)</p> <p>6. The facility failed to provide Active Treatment Schedules for Client #2 which directed staff on how and when to implement activities designed to teach independence during the course of Client #2 's day. This failure prevented the Client from having staff who knew what and when to do meaningful activities with him throughout the day. (See W250 for details.)</p> <p>7. The facility failed to ensure the data collected on skill training objectives for Clients #2, #4 and #8 was measurable in order to determine whether the Clients were learning the skill. This failure</p>	{W 195}		
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{W 195}	<p>Continued From page 8</p> <p>prevented the facility from accurately determining whether the Clients were making progress on learning the skill. (See W252 for details).</p> <p>8. The facility failed to ensure Client #11 had an IHP that had been modified or changed after he had successfully accomplished the objective. This failure resulted in the Client not receiving training on other identified needs. (See W255 for details.)</p> <p>9. The facility failed to ensure Client #7 had his IHP modified after he showed continuous regression in a training objective over 6 continuous months. This failure resulted in the Client continuing to work on a skill on which he was not making progress. (See W256 for details.)</p> <p>10. The facility failed to ensure Client #12 had his Comprehensive Functional Assessment (CFA) updated in response to a significant change in his functioning due to a mental health crisis. This failure to update and change the CFA prevented the facility from having a clear picture of the Client ' s current strengths and weaknesses in order to meet his current needs. (See W259 for details.)</p> <p>11. The facility failed to ensure Clients #1 and #4 had consents from the Human Rights Committee (HRC) for their psychotropic medications. This failure resulted in the Clients receiving psychotropic medications that had not been approved. (See W262 for details.)</p>	{W 195}		

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{W 195}	Continued From page 9	{W 195}			
{W 214}	<p>12. The facility failed to ensure Clients #1 and #4 had current signed informed consents for psychotropic medications within the required 30 days. This failure resulted in the Clients and Legal Guardians unable to give consent for the administration of medication. (See W263 for details.)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure appropriate dining skills in 1 of 5 Expanded Sample Clients (Client #11) was identified and supports put in place to insure his safety. This failure impacts Client #11 's ability to eat in public by having negative attention drawn to him and ensuring sanitary dining conditions.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Observation on 1/11/16 at 11:00 AM at 1040 Quinault Court (QC) revealed Client #11 was crouched, leaning on the kitchen wall, next to the kitchen door. His plate was full of food and sitting on the floor to the left of his feet, in the doorway from the kitchen. The Surveyor had to step over the plate to exit the kitchen.</p>	{W 214}			

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{W 214}	Continued From page 10  Observation on 1/12/16 at 8:20 AM at 1040 QC revealed Client #11 crouched, leaning on the kitchen wall, next to the kitchen door with a bottle of juice sitting on the floor to the left of his feet obstructing the doorway. The Surveyor had to step over the juice to exit the kitchen.  Record review on 1/13/16 at 9:20 AM of Client #11 ' s Individual Habilitation Plan (IHP) dated 7/16/15 and Comprehensive Functional Assessment (CFA) dated 7/8/15 revealed Health and Safety considerations for eating but the IHP did not address the problem of eating on the floor.  Interview on 1/11/16 at 11:00 AM with the Direct Care Staff supervising Client #11 revealed Client #11 chose to eat his lunch in the kitchen on the floor that day.  Interview on 1/14/16 at 10:00 AM with Staff K, E and F verified when Client #11 eats on the floor, it is not sanitary and verified appropriate dining skills were not identified as a need in the IHP or the CFA.	{W 214}			
{W 229}	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN  The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.  This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure 1 of 10 Sample Clients (Client #5) had an objective that was written in singular fashion with only one	{W 229}			

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{W 229}	<p>Continued From page 11</p> <p>discrete behavior being trained and monitored. Objective #1021 instructed Client #5 to set a dining table and to gather utensils from a cabinet. Failure of the facility to ensure that objectives were written in a singular format prevented staff from determining which specific skill Client #5 was learning, maintaining or showing progression in.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Observation on 1/11/16 at 11:45 AM at 1030 Quinault Court (QC) revealed Direct Care staff cued Client #5 to go to the dining room cabinet and get his dishes from the cabinet and set his place at the table in preparation for lunch. Client #5 grabbed a dinner plate and a glass from the cabinet and placed them on the table.</p> <p>Record review on 1/13/15 at 8:30 AM of Client #5 ' s Individual Habilitation Plan (IHP) dated 6/30/15 revealed Objective #1021: " With a verbal cue, [Client #5 ' s first name] will prepare his place setting for meals including getting his dishes from the cabinet, utensils and setting his place at the table with 85% accuracy or greater for 6 consecutive months. "</p>	{W 229}		
{W 231}	<p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.</p>	{W 231}		

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{W 231}	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure terms describing behaviors to be changed/replaced in 1 of 10 Sample Clients (Client #4) were defined. This failure resulted in the facility using a training objective which lacked quantifiable terms. In addition this failure prevented the facility from ensuring all staff knew what behavior to look for in Client #4, how to train him, how staff were to determine how he was feeling, if his feelings were appropriately being expressed, how the accuracy of his emotional expression was to be determined and how to know if he was learning the skills being taught. This put him at risk of not learning skills which would make him more independent.</p> <p>Findings include:</p> <p>Record review on 1/13/16 at 3:39 PM of Client #4 's Individual Habilitation Plan (IHP) dated 6/2/15 revealed Objective #3006: "[Client #4 's first name] will appropriately express his feelings and emotions with 100% accuracy for 11 of 12 consecutive months. " The Positive Behavior Support Plan (PBSP) dated 8/7/15 did not give specific directions on how staff were to determine how Client #4 was feeling, if his feelings were appropriately being expressed, or how the accuracy of his emotional expression was to be determined.</p> <p>Interview with Staff A, B, and C on 1/14/16 at 8:05 AM, verified the PBSP did not tell how staff were to determine how Client #4 was feeling, if his feelings were appropriately being expressed, or how the accuracy of his emotional expression</p>	{W 231}		

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{W 231}	Continued From page 13 was to be determined.	{W 231}		
{W 234}	<p>483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide instructions on skill training programs for 3 of 10 Sample Clients (Client #4, #5, and #8) which provided enough information and detail to ensure that all staff across all days and shifts would train these Clients in exactly the same way. This failure put Clients at risk of not receiving consistent training on needs identified as important and potentially put Clients at risk of not learning the skills which would allow them to become more independent.</p> <p>Findings include:</p> <p>Record review of Client #4 on 1/13/16 at 3:40 PM revealed:</p> <p>1. The data sheet for Objective #1071 for Handwashing, included the teaching method topics of Positive Behavior Support Plan (PBSP) precautions, the need to cue, to correct using re-cue, further assistance, or a reinforcer, reinforcement, start date, and materials needed. However, it lacked details of specifically how staff were to do these things so that all staff would say and do the same thing each time.</p> <p>The program omitted other teaching details to ensure all staff across all shifts would conduct the training in the same way, for example: Objective</p>	{W 234}		

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{W 234}	<p>Continued From page 14</p> <p>#1071 for Handwashing did not include how long Client #4 should wait for a response, how to respond if he refuses, examples of cue responses, etc.</p> <p>The in-service roster for Objective #1071 restated the Individual Habilitation Plan (IHP) objective in " Short Summary of Training " section and did not provide further instruction.</p> <p>2. Objectives #1007 for cutting a snack, #1104 for using a hanky to wipe his mouth, and #1136 for laundering an item revealed the same issues. Reinforcement was consistent for Objectives #1071, #1007, #1136 and #1104 despite different training needs and locations being carried out.</p> <p>Interview of Staff A and B about Clients #4 and #8 on 1/14/16 at 8:05 AM, verified the staff instructions were not clear on the in-service rosters or program/data sheets.</p> <p>Record review of Client #5 on 1/13/16 at 8:30 AM revealed:</p> <p>1. The data sheet for Objective #1097 to brush teeth, included the teaching topics of precautions, the need to cue, materials needed, correction, reinforcement, and start date. However, it lacked details of specifically how staff were to do these things so that all staff would say and do the same thing each time.</p> <p>The program omitted other teaching details to ensure all staff across all shifts would conduct the training in the same way, for example: Objective #1097 for tooth brushing did not include how to approach Client #5 if he refuses the first prompt,</p>	{W 234}		

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{W 234}	<p>Continued From page 15</p> <p>how many times he can be re-cued, when/if to apply toothpaste, details on how to brush his teeth, where supplies are kept, other details such as if he applies toothpaste before getting the toothbrush wet, use of mouthwash, etc.</p> <p>2. Objectives #1021 to prepare a place setting, #1118 to complete a laundry routine, and #1126 to prepare a meal/snack revealed the same issues.</p> <p>Reinforcement was consistent for Objectives #1097, #1021, #1118, and #1126 despite different training needs and locations being carried out.</p> <p>Interview on 1/14/16 at 8:30 AM with Staff G, H, and J verified each of the 4 identified teaching plans did not have enough information in them to effectively assist staff to implement each teaching plan in a consistent manner for Client #5.</p> <p>Record review of Client #8 on 11/13/16 at 8:40 AM revealed:</p> <p>1. The data sheet for Objective #1097 for tooth brushing, included the teaching method topics of PBSP precautions, the need to cue, to correct Client #8 by re-cueing, and reinforcement. However, it lacked details of specifically how staff were to do these things so that all staff would say and do the same thing each time.</p> <p>The program omitted other teaching details to ensure all staff across all shifts would conduct the training in the same way, for example: Objective #1097 for tooth brushing did not include what to do if Client #8 refused the first prompt, how many times he could be re-cued, details regarding</p>	{W 234}		

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{W 234}	Continued From page 16 where supplies are kept or how they should be presented to Client #8 at the start of the program, if Client #8 preferred his left or right hand, and other details such as if he applied toothpaste before getting the toothbrush wet, etc.  The in-service roster for Objective #1097 restated the IHP objective and included when to run the program and take data in the " Short Summary of Training " section but did not provide further instruction or any additional details.  2. Objective #2075 for signing one word [using American Sign Language], Objective #2227 for taking clothes off hangers, Objective #1167 for putting money in his wallet, and Objective #1126 for preparing a lunch or snack revealed the same issues.  Reinforcement was consistent for Objectives #2227, #2075, and #1167 despite different training needs and locations being carried out. Reinforcement was consistent for Objectives #1126 and #1097 despite different training needs and locations being carried out.  Interview of Staff A and B about Clients #4 and #8 on 1/14/16 at 8:05 AM, verified the staff instructions were not clear on the in-service rosters or program/data sheets.	{W 234}			
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	{W 249}			

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{W 249}	<p>Continued From page 17 objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 2 of 10 Sample Clients (Clients #2 and #8) and 1 of 5 Expanded Sample Clients (Client #11) had Individual Habilitation Plans (IHP) that were implemented as they were written. This failure prevented the Clients from receiving training for their current needs and prevented them from having the opportunity to become more independent.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Client #2</p> <p>1. Record review on 1/14/16 at 10:40 AM revealed Client #2 had Objective #1136 to launder his clothing as needed and data was to be recorded 1 time per week. A review of Client #2 's Total Task and Data Sheets revealed that for the month of October 2015 data was not recorded for 3 weeks. For August 2015, November 2015 and December 2015 data was not recorded for 2 weeks for each of those months.</p> <p>2. Record review on 1/14/16 at 10:40 AM revealed that Client #2 had Objective #1111 to</p>	{W 249}		
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{W 249}	<p>Continued From page 18</p> <p>independently complete his AM and PM hygiene routine and data was to be recorded separately for each shift 3 times per week. A review of Client #2 ' s Total Task and Data Sheets for the AM shift revealed: September 2015 through November 2015 no data was collected to fulfill the 3 times in one week requirement, and for December 2015 no data was collected for 3 weeks. For the PM shift, the Total Task and Data Sheets revealed there was no data to fulfill the 3 times in one week requirement collected for 4 months from September 2015 through December 2015.</p> <p>3. Record review on 1/14/16 at 10:40 AM revealed that Client #2 had Objective #1097 to brush his teeth twice daily and data was to be recorded 3 times a week. A review of Client #2 ' s Total Task and Data Sheets revealed no data to fulfill the 3 times in one week requirement was recorded for a 4 month period from September 2015 through December 2015.</p> <p>An interview with Staff D on 1/14/16 at 10:53 AM verified that staff were not recording data for Client #2 ' s IHP objectives as often as required.</p> <p>Client #8</p> <p>1. Observation of Client #8 on 1/11/16 at 1010 Quinault Court (QC) at 11:39 AM revealed he finished his lunch, went to his bedroom and laid down on his bed. At 11:56 AM, when the observation ended, no staff had gone into his room to check on him.</p> <p>Record review on 1/13/2016 at 8:40 AM of Client #8 ' s IHP dated 9/8/15 revealed he has</p>	{W 249}		

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{W 249}	<p>Continued From page 19</p> <p>Gastroesophageal reflux disease (GERD) and " is also encouraged to sit up after meals" and "encourage [Client #8 ' s first name] not to go to bed right after he eats."</p> <p>Interview with Staff A on 1/14/16 at 8:05 AM, verified Client #8 was to stay up after meals " because of GERD. " He verified staff had not correctly implemented Client #8 ' s IHP.</p> <p>2. Record review on 1/13/16 at 8:40 AM of Client #8 ' s IHP dated 9/8/2015 revealed Service Care Plan #1161 stated " money management skills have been assessed to determine his needs in this area. Appropriate money management training will be developed in the near future " and the completion of development of appropriate training was to be " completed ASAP. "</p> <p>Review of Staff training on Objective #1167 for money management revealed the program was written and training occurred on 1/8/16, 4 months after the IHP dated 9/8/15.</p> <p>Interview of Staff B on 1/14/16 at 8:05 AM, verified Client #8 had not received training for money management until 1/11/16, 4 months after his IHP dated 9/8/15.</p> <p>Client #11</p> <p>1. Record review on 1/13/16 at 9:20 AM of Client #11 ' s IHP dated 7/16/15 and the Qualified Intellectual Disabilities Professional (QIDP) Active Treatment Review form revealed training Objective #1092 to take a shower. Data revealed</p>	{W 249}		

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{W 249}	<p>Continued From page 20</p> <p>Client #11 was declining in his skill level to shower from 36% in May 2015, 16% in June 2015, 12% in July 2015, .08% in August 2015, 7% in September 2015, 3% in October 2015 and 3% in December 2015.</p> <p>2. Record review on 1/13/16 at 9:20 AM of Client #11 ' s IHP dated 7/16/15 and the QIDP Active Treatment Review form revealed training Objective #1169 sign a cash withdrawal slip. Data revealed the training objective for signing for a cash withdrawal had not been implemented from July 2015 to December 2015, noting " No Data. "</p> <p>3. Further record review on 1/13/16 at 10:30 AM revealed an AD HOC dated 3/5/15 and a Service Care Plan (SCP) #1115.2 located within the IHP that outlined steps to ensure Client #11 showered 2 times a week for adequate hygienic health. Review of a Format 13 Data tracking sheets revealed Client #11 had not showered for 17 consecutive days/nights during November 2015 and 16 consecutive days/nights during December 2015.</p> <p>Interview on 1/14/16 at 10:00 AM with Staff K, E and F verified Client #11 had specific training programs (#1092, SCP #1115.2 and AD HOC) designed to assist him with showers. They verified that the data indicated that staff were not implementing Objective #1092 shower program consistently. Staff K was unable to produce data sheets confirming Objective #1169 to sign a cash withdrawal was implemented.</p> <p>4. Observation on 1/12/16 at 10:40 AM at 1040 QC revealed Client #11 sleeping in his room on a bare mattress placed on the floor with one blanket on him.</p>	{W 249}			

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{W 249}	Continued From page 21  Record review on 1/13/16 at 9:20 AM of Client #11 ' s IHP dated 7/16/15 revealed a mechanical support list that noted Client #11 was to use a bedframe with short legs to improve environment and physical hygiene and Service Care Plan (SCP) #1115.1 gave staff instructions to daily work with Client #11 to use his bed and to ensure he had a clean sheet on his mattress to prevent boils. Client #11 was to use the bedframe with short legs to allow enough space to mop under the bed 2x daily (to adequately clean up urination) and to prevent Client #11 from stubbing his toes.  Interview on 1/14/16 at 10:00 AM with Staff K, E and F verified that Client #11 had a bedframe with short legs but Client #11 had thrown it out of his room and the bed was now on the back porch of the house. They also verified staff were not implementing the training daily as described in the IHP.	{W 249}		
{W 250}	483.440(d)(2) PROGRAM IMPLEMENTATION  The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.  This STANDARD is not met as evidenced by: Based on interviews and record review the facility failed to provide Active Treatment Schedules for 1 of 10 Sample Clients (Client #2) which directed staff on how and when to implement activities designed to teach independence over the course of Client #2 ' s day. This failure prevented Client #2 from having	{W 250}		

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{W 250}	<p>Continued From page 22</p> <p>staff who knew what activities to teach and when to teach them throughout his day.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Record review on 1/13/16 at 11:23 AM revealed Client #2 ' s Active Treatment Schedule stated " 0630-0730 Morning ADLs; 07:30-08:45 Pre meal, Breakfast, Post meal; 0845-1100 Prep for Work/ Robin, Weekends recreational activities or when canceled; 1100-1200 Pre meal, lunch, Post meal; 1200-1500 Rec/Leisure activities; 1500-1630 Pre meal, dinner, Post meal; 1630-1800 Rec/leisure-Social; 1800-2000 Rec/leisure, Social and 1900-2200 Leisure, Recreation, Social, Evening ADLs, Leisure Prepare for bed. " The Active Treatment Schedule also stated " Work on IHP objectives daily: 1111 AM and PM Hygiene routine, 1097 improve oral hygiene and 1136 improve laundry skills. "</p> <p>Interview with Staff D on 1/14/16 at 8:20 AM verified that the Active Treatment Schedule for Client #2 lacked specificity and detail on what staff should be doing with Client #2 over the course of the day.</p>	{W 250}		
{W 252}	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable</p>	{W 252}		

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{W 252}	Continued From page 23 terms.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the data collected on skill training objectives accurately measured whether Clients were learning the skill for 4 of 10 Sample Clients (Client #2, #4, #7, and #8). The facility practice was to break the skill identified in the objective into several small steps. Staff then recorded how the Client did on each small step each time the Client was trained. The Qualified Intellectual Disability Professionals (QIDP) then averaged the scores from all the small steps and used this as the measure of progress on the objective rather than directly measuring the number of times the objective had been completed. The QIDP did not determine how many times the Client had performed the skill as stated in the objective. This failure prevented the facility from accurately determining whether the Clients were making progress on learning the skill.  This is a repeat citation from the survey on 11/20/15.  Findings include:  Client # 2  Record review on 1/14/16 at 10:40 AM of Client #2 's Individual Habilitation Plan (IHP) revealed: 1. Objective #1097 stated: "[Client #2 's first name] will independently brush his teeth at least twice daily with 75% accuracy or greater for 3 of 5 consecutive months. "	{W 252}			

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{W 252}	<p>Continued From page 24</p> <p>Review of the Data Sheet revealed the facility had broken the objective task into 7 separate steps encompassing brushing teeth. Each step could be scored independently, 1 verbal cue, 3 or more verbal cues and modeling.</p> <p>Review of the Data Sheet for the month of December 2015 revealed Client #2 's performance on each step was variable and inconsistent throughout the month.</p> <p>2. Objectives #1111 for AM and PM hygiene routine and Objective #1136 for laundering revealed the same issue.</p> <p>Interview on 1/14/16 at 8:08 AM with Staff D verified the way the facility was taking data did not allow them to know if the training objective was being met.</p> <p>Client #4</p> <p>Record review on 1/13/16 at 3:39 PM of Client #4 's IHP dated ---6/2/15 revealed:</p> <p>1. Objective #1104: "[Client #4 's first name] will independently use a hanky/cloth or tissue to wipe his mouth at times as needed with 100% accuracy for 5/6 consecutive months. "</p> <p>Review of the Data Sheet revealed the facility had broken the task into 2 separate steps encompassing using a hanky. Each step could be scored as independent, gesture, verbal cues, gesture and verbal cues, and client unwilling to</p>	{W 252}		

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{W 252}	<p>Continued From page 25 participate.</p> <p>Review of the Data Sheet for the month of December 2015 revealed Client #4 ' s performance on each of the steps was variable and inconsistent throughout the month.</p> <p>2. Objectives #1071 for handwashing and #1136 for laundering an item revealed the same issues.</p> <p>Interview with Staff A, B, and C on 1/14/16 at 8:05 AM verified the way the facility was taking data did not allow them to know if the training objective was being met.</p> <p>Client #7</p> <p>1. Observation on 1/11/16 at 11:30 at 1040 Quinault Court (QC) revealed Client #7 sitting at the dining room table for lunch. He independently lifted the juice container and poured juice into his cup, spilling some on the table and floor.</p> <p>Observation on 1/12/16 at 8:15 AM at 1040 QC revealed Client #7 sitting at the dining room table having breakfast. His glass was empty and Staff assisted him to pour the juice with hand over hand assistance because the juice container was full.</p> <p>Record review on 1/13/16 at 9:20 AM of Client #7 ' s IHP dated 5/21/15 revealed Objective #1010: " [Client #7 ' s first name] will independently pour his liquids without spilling with 85% or greater accuracy for 8 of 10 consecutive months, by 05/16. " Review of Total Task Program Data Sheet for Objective #1010 reveled data with</p>	{W 252}		

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{W 252}	<p>Continued From page 26</p> <p>steps: 1. Grab handle 2. Pick up pitcher 3. Pour liquids 4. Set pitcher on table. The program sheet did not measure if liquids had been spilled or not.</p> <p>Interview on 1/14/16 at 9:30 with Staff K, E and F verified that Direct Care Staff document on if/when Client #7 poured liquids and not if he had spilled any. They concurred that pouring liquids and not spilling liquids were two separate skills for Client #7 to acquire and the data collected would not allow them to know if the training objective was being met.</p> <p>Client #8</p> <p>1. Record review on 1/13/16 at 8:40 AM of Client #8 ' s IHP dated ---9/8/15 revealed Objective #1097: " [Client #8 ' s first name] will independently brush his teeth with 80% accuracy for 5/6 consecutive months. "</p> <p>Review of the Data Sheet revealed the facility had broken the task into 8 separate steps encompassing brushing his teeth. Each step could be scored as independent, partial physical assistance, full physical assistance, and client unwilling to participate.</p> <p>Review of the Data Sheet for the month of December 2015 revealed Client #8 ' s performance on each of the steps was variable and inconsistent throughout the month.</p> <p>Interview with Staff A, B, and C on 1/14/16 at 8:05 AM verified the way the facility was taking data did not allow them to know if the training objective</p>	{W 252}			

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{W 252}	Continued From page 27 was being met.	{W 252}		
{W 255}	<p>2. Objectives #1167 for putting money into his wallet, Objective #2227 for taking clothes off hangers, and Objective #1126 for preparing a lunch or snack revealed the same issues.</p> <p>Interview with Staff A, B, and C on 1/14/16 at 8:05 AM verified the way the facility was taking data did not allow them to know if the training objective was being met.</p> <p>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE</p> <p>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 a completed objective for 1 of 5 Expanded Sample Client 's (Client #11) Individual Habilitation Plan (IHP) was identified, modified or changed to meet the needs or accomplishments of the Client. This failure prevented Client #11 from having other needs identified, from being taught new training skills and from becoming more independent in other life skills.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Record review on 1/13/16 at 9:35 AM of Client</p>	{W 255}		

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{W 255}	<p>Continued From page 28</p> <p>#11 ' s IHP dated 7/16/15 revealed training Objective #2082: " [Client #11 ' s first name] will hold a reality based conversation for at least 1 minute with 96% or greater accuracy for 10 of 12 consecutive months by 07/16. " Review of the Qualified Intellectual Disabilities Professional (QIDP) Active Treatment Review form was not dated but showed data scores for Objective #2082 for 11 consecutive months of scores at or above 96%. The undated Active Treatment Review Form was for the review period of September 2015 - November 2015, but also showed data scores for Objective #2082 for January 2015 through November 2015.</p> <p>Interview on 1/14/16 at 10:00 AM with Staff E and F verified the data showed Client #11 had met criteria for Objective #2082 when the past consecutive 12 months (January - November 2015) were reviewed. Staff E and F revealed they only count the consecutive months starting at the IHP date and do not consider his progress at the time of the update even though the objective and criteria did not change.</p>	{W 255}		
{W 256}	<p>483.440(f)(1)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to modify or change an objective in the Individual Habilitation Plan (IHP)</p>	{W 256}		

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{W 256}	<p>Continued From page 29 for 1 of 10 Sample Clients (Client #7). Client #7 showed continuous regression in a training objective for 6 consecutive months. This failure resulted in Client #7 continuing to work on a skill on which he was not making progress and the facility did not attempt to make any changes.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Observation on 1/11/16 at 11:30 at 1040 Quinault Court (QC) revealed Client #7 sitting at the dining room table for lunch. He independently lifted the juice container and poured juice into his cup, spilling some on the table and floor.</p> <p>Observation on 1/12/16 at 8:15 AM revealed Client #7 sitting at the dining room table having breakfast. Staff assisted Client #7 to pour the juice with hand over hand assistance because the juice container was full.</p> <p>Record review on 1/13/16 at 9:20 AM of Client #7 's IHP dated 5/21/15 revealed Objective #1010: "[Client #7 's first name] will independently pour his liquids without spilling with 85% or greater accuracy for 8 of 10 consecutive months, by 05/16." Review of the Qualified Intellectual Developmental Professional (QIDP) Active Treatment Review form, dated a review period of September 2015 through November 2015, revealed a decline of skill level from: 100% in May 2015, 59% in June 2015, 67% in July 2015, 48% in August 2015, 48% in September 2015, 28% in October 2015 and 26% in November 2015.</p>	{W 256}			

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{W 256}	Continued From page 30 Interview on 1/14/16 at 9:30 AM with Staff E verified Client #7 had showed 6 consecutive months of skill accusation decline, he had not analyzed the data and the program had not been revised.	{W 256}		
{W 259}	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was an updated Comprehensive Functional Assessment (CFA) for 1 of 5 Expanded Sample Clients (Client #12) when he experienced a significant change in functioning due to a mental health crisis. Failure to update and change the CFA prevented the facility from having a clear picture of the Client 's current strengths and weakness so that an Individual Habilitation Plan (IHP), which met the current needs, could be developed.</p> <p>This is a repeat citation from the survey on 11/20/15.</p> <p>Findings include:</p> <p>Client #12</p> <p>Record Review on 1/14/16 at 2:15 PM revealed the CFA dated 9/03/15 for Client #12 had not been updated after a significant mental health decompensation episode which occurred in April 2015.</p>	{W 259}		

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{W 259}	Continued From page 31	{W 259}			
{W 262}	<p>Interview on 1/14/16 at 2:50 PM with Staff J verified the CFA had not been updated as a result of the significant change in functioning in April 2015.</p> <p>The facility submitted a letter of Credible Allegations with a Plan of Correction, stating this citation (naming this particular Client) would be corrected by 12/18/15.</p> <p><b>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</b></p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were current, signed informed consents for psychotropic medication for 2 of 10 Sample Clients (Clients #1 and #4). The facility was unable to provide documentation of any current approvals for the use of psychotropic medications by Client #1 and #4 (to manage behaviors) by the Human Rights Committee (HRC). This failure resulted in Clients receiving drugs to manage their behaviors which had not been approved by the HRC.</p> <p>Findings include:  Client #1</p>	{W 262}			

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

PRINTED: 02/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50G047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/04/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD</b> <b>BUCKLEY, WA 98321</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 262}	<p>Continued From page 32</p> <p>Record review on 1/13/16 at 8:40 AM of a Psychoactive Medications and Consents list dated 1/12/16 provided by the pharmacy revealed there were no consents for the following listed psychotropic medications: Lurasidone, Clonazepam, Pregablin, Citalopram, Metoprolol Tartrat and Prazolin.</p> <p>Interview with Staff C on 1/14/16 at 9:34 AM revealed she could not locate the psychotropic medication consents in Client #1 's program book. At 9:58 AM Staff C reported she had spoken with the facility 's physician who suggested the consents could be with Staff L at the placement office. Interview by phone on 1/14/16 at 10:00 AM with Staff L at the placement office revealed he did not have the consents for Client #1 's psychotropic medications.</p> <p>Client #4</p> <p>Record review on 1/14/16 at 3:39 PM of Client #4 's Individual Habilitation Plan (IHP) dated 6/2/15 revealed " He is being effectively maintained on clozapine and lithium. The psychiatrist recommends no changes to his psychotherapeutic medications. "</p> <p>Record review on 1/13/16 at 3:39 PM of Client #4 's file revealed the consents for Clozapine and Lithium had not been signed by the Legal Guardian.</p> <p>Interview with Staff C on 1/14/16 at 8:05 AM revealed a verbal consent had been obtained on 8/7/15 from the Legal Guardian. She verified there was not a current signed consent by the</p>	{W 262}		

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NAME OF PROVIDER OR SUPPLIER  <b>RAINIER SCHOOL PAT C</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>RYAN ROAD</b> <b>BUCKLEY, WA 98321</b>
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{W 262}	Continued From page 33 Legal Guardian.	{W 262}		
{W 263}	<p>Record review on 1/14/16 of the facility Standard Operating Procedures 3.09 Consent revealed " Telephone consent is valid for 60 days. " Review of Standard W263 revealed consents should be authenticated in writing within 30 days.</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there were current signed informed consents from the Legal Guardian for psychotropic medication for 2 of 10 Sample Clients (Clients #1 and #4). The facility was unable to provide documentation of any consent from the Legal Guardian for Client #1, and #4 had telephonic consent which was past 30 days. This failure resulted in medication being given to clients prior to Legal Guardian approval.</p> <p>Findings include:</p> <p>1. Record review on 1/13/16 at 8:40 AM of Psychoactive Medications and Consents list dated 1/12/16 provided by the pharmacy for Client #1 revealed there were no consents for the following psychotropic medications: Lurasidone, Clonazepam, Pregablin, Citalopram, Metoprolol Tartrat and Prazolin.</p>	{W 263}		

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{W 263}	<p>Continued From page 34</p> <p>Interview with Staff C on 1/14/16 at 9:34 AM revealed that she could not locate the psychotropic medication consents in Client #1 ' s program book. At 9:58 AM Staff C reported that she had spoken with the facility ' s physician who suggested the consents could be with the Staff L at the placement office.</p> <p>Interview by phone on 1/14/16 at 10:00 AM with Staff L in the placement office revealed he did not have the consents for Client #1 ' s psychotropic medications.</p> <p>2. Record review on 1/14/2016 at 3:39 PM of Client #4 ' s Individual Habilitation Plan (IHP) dated 6/2/15 revealed: " He is being effectively maintained on clozapine and lithium. The psychiatrist recommends no changes to his psychotherapeutic medications. "</p> <p>Record review on 1/13/16 at 3:39 PM of Client #4 ' s file revealed the consents for Clozapine and Lithium had not been signed by the Legal Guardian.</p> <p>Interview with Staff C on 1/14/16 at 8:05 AM revealed a verbal consent had been obtained on 8/7/15 from the Legal Guardian. She verified there was not a current signed consent by the Legal Guardian.</p> <p>Review on 1/14/16 of the facility Standard Operating Procedures 3.09 Consent revealed " Telephone consent is valid for 60 days. " Review of Standard W263 revealed consents should be authenticated in writing within 30 days.</p>	{W 263}		

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STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
Aging and Long-Term Support Administration  
Residential Care Services  
PO Box 45600, Olympia, WA 98504-5600

May 8, 2015

**By Facsimile and Certified Mail (7007 1490 0003 4195 0246)**

**Notice of the denial of Payment for New Admissions Remedy – Please Read Carefully**

Harvey Perez, Superintendent  
Rainier School PAT A  
PO Box 600  
Buckley, Washington 98321

RE: Recertification Survey  
3/2/2015 through 3/11/2015  
-Denial of Payment Remedy

Dear Mr. Perez:

The Division of Residential Care Services (RCS) of the Aging and Long-Term Support Administration (ALTSA) will be imposing the Denial of Payment for New Admissions Sanction at Rainier School PAT A. The reasons for this decision, the time frame for imposition of the remedy, and your appeal rights are described below.

From March 2, 2015 through March 11, 2015, survey staff from RCS conducted a survey at Rainier School PAT A. Based on that survey, RCS determined that Rainier School PAT A is out of compliance with three federal conditions of participation (CoPs) for facilities certified to provide Medicaid Title XIX ICF/IID services. Compliance with all Conditions of Participation (CoPs), found in 42 Code of Federal Regulations (CFR) 483 Subpart 1, is required for certification. The survey completed on March 11, 2015, found that Rainier School PAT A failed to comply with the following CoPs:

- W102 – 42 CFR 483.410 Governing Body and Management
- W122 – 42 CFR 483.420 Client Protections
- W195 – 42 CFR 483.440 Active Treatment Services

The deficiencies are described in "Form CMS-2567", a copy of which you received on April 3, 2015. The cited deficiencies indicate limitations in Rainier School PAT A's capacity to adequately exercise operating direction over the facility and by failures to provide client

protections and active treatment services. Significant corrections will be required before the facility can be found to be in compliance.

### **The Denial of Payment Remedy**

RCS has elected to impose the denial of payments for new admissions remedy.

This notice is being provided as required by 42 CFR 442.118 and; SOM 3006, which requires notice to the facility of imposition of the denial of payment remedy if it will not be able to correct within 60 days following the last day of the survey. May 10, 2015, is the 60<sup>th</sup> day following the survey. Your appeal rights and the time frame for implementation of the denial of payments are described in the following paragraphs.

Denial of payment for new admissions is an alternative to termination from the Medicaid Title XIX ICF/IID program. (Under the termination remedy, RCS would have to terminate Rainier School PAT A from the Medicaid program if it did not achieve substantial compliance with federal requirements by June 9, 2015 (42 CFR 442.101 (3) (e); SOM 3005 E; SOM 3012). If RCS determines that Rainier School PAT A is in substantial compliance with the CoPs before the denial of payment for new admissions takes effect, then the remedy will not be implemented.

### **Appeal Rights**

Prior to implementation of the denial of payment for new admissions remedy, you have the right to request an informal hearing before an official who was not involved in making the initial determination (42 CFR 442.118). During the informal hearing you may present evidence or documentation in writing or in person to refute the determination that the facility is out of compliance with the CoPs. A request for the informal hearing must be received on or before **May 22, 2015**.

If an informal hearing is not requested within ten working days, the denial of payment remedy will take effect immediately. If you request a hearing, and the hearing decision upholds RCS's findings of noncompliance with the conditions of participation, the remedy will be implemented after the facility and the public has been provided 15 days notice of the imposition of the remedy.

Once implemented, the denial of payment remedy will continue in effect for eleven (11) months unless RCS finds that: 1) the deficiencies have been corrected, 2) Rainier School PAT A is making a good faith effort to achieve compliance, or 3) the deficiencies make it necessary to terminate the facility.

Harvey Perez  
May 8, 2015  
Page 3

*Loida*

You may request an informal hearing by sending a written request to:

Carl I Walters II  
Director, Residential Care Services  
P.O. Box 45600  
Olympia, WA 98504-5600

The request should identify the issues you plan to raise during the hearing.

If you have any questions concerning the instructions contained in this letter, please contact me at (360) 725-2405.

Sincerely,



Loida Baniqued, Chief of HQ Operations  
ICF/IID Survey and Certification Program  
Residential Care Services

cc: CMS Regional Office, Washington State ICF/IID Team  
Bill Moss, Assistant Secretary of ALTSA  
Carl I. Walters II, Director of RCS  
Donna Cobb, Senior Counsel  
Evelyn Perez, Assistant Secretary of DDA  
Donald Clintsman, Deputy Assistant Secretary of DDA  
Janet Adams, DDA Office Chief  
Larita Paulsen, DDA QM Unit Manager  
Bruce Work, Medicaid Compliance Administrator  
Kari Mohr, Health Care Authority

