“Shut Them Down:”*

It’s time to close Washington’s Dangerous Residential Habilitation Centers

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Title credit: Mike Raymond, President of People First of Washington and former resident of Rainier School.


Cover image description: Screenshot of a news report showing a rural logging road, with a banner at the bottom reading, “Search suspended for developmentally disabled man – Buckley, Pierce County.”
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Introduction

Over six hundred people with developmental and intellectual disabilities still live in Washington’s four state-run Residential Habilitation Centers (RHCs). These institutions exist to fulfill two promises to the people who live there: 1) a safe place to live, and 2) appropriate supports to learn the skills they need to live with as much self-determination and independence as possible, including moving to a community-based setting. The institutions have broken these two promises. Day after day, for years on end, they fail to keep residents safe and fail to deliver appropriate services. They have been given every chance to improve, but continue to fall short of even minimum standards.

It is time for action from Washington State to protect the lives of people with developmental disabilities and require the closure of the outdated, segregated, and dangerous RHCs. Currently, we have a unique opportunity to update and dramatically improve Washington’s service system for people with developmental disabilities through a joint executive and legislative taskforce. This taskforce is charged with engaging stakeholders to develop a plan for the future of services for people with developmental disabilities by September 2021. The plan should solidify the decision to deinstitutionalize services for people with developmental disabilities in Washington State, improving safety and quality of life.

In 2017, a resident returned to the Rainier School following an elective outpatient surgery. Rainier did not incorporate post-surgical instructions into a comprehensive plan of care and failed to recognize the resident’s shortness of breath as an indication of post-operative complications. The woman died several days later. See pg. 9

In winter 2020, a resident left his RHC cottage and walked off into the winter night. For three days during bad weather a search of the vast wooded area surrounded the RHC ensued. Searchers found the resident’s sweatshirt a mile from the RHC, but never found the resident. See pg. 12
People with developmental disabilities have been calling for the closure of the RHCs for many years. Policy makers should be guided by this clear call to close RHCs and take the necessary action to end the repeated failure of RHCs to meet minimum regulatory standards and to keep residents safe from harm by ending these institutions. The time for considering reforms of the RHCs is over – people with developmental disabilities deserve better than segregated, and frequently harmful, institutional care. Our state has the power to abolish the RHCs for good and to contribute to a better future, free from the threat of institutionalization, for all Washingtonians with intellectual and developmental disabilities.

Background

A Documented History of Failures

The harms detailed in this report are not unique or unprecedented – they are part of a long history of abuse and neglect in Washington’s RHCs. In 2017, Disability Rights Washington released a report entitled No Excuses, exposing abuse, neglect, and mistreatment of residents at Washington’s RHCs. People with intellectual and developmental disabilities suffered death, sexual assault, choking, malnourishment, and a lack of medical care. They also were denied the skills training that these facilities ostensibly exist to provide. Three more reports by DRW in 2018 and 2019 emphasized that problems arising year after year are not isolated events, but the results of organizational deficiency and chronic poor leadership that was
described by the state’s own independent contractor as “chaotic” and “dangerous.”

This report builds on Disability Rights Washington’s previous work and documents the human stories behind recent regulatory actions and federal funding cuts. The issues called out by DRW in 2017, 2018, and 2019 have not been fixed – people with developmental disabilities are still languishing, sometimes for decades, in segregated institutions where they are continually at risk for verbal, physical, and sexual abuse and neglect.

In the past several years, each of the intermediate care facilities (ICFs) at our state’s RHCs have faced licensing enforcement actions for failures to comply with the minimum legal requirements for adequate care found in Medicaid’s nine Conditions of Participation. Federal funding for one of the licensed settings (Rainier School’s group of residential cottages known as PAT A) was terminated due to chronic noncompliance and was closed last year. Another license has been on the brink of the same fate as dangerous deficiencies persisted for nearly all of 2020. State and federal regulators determined that over 80 people living at Rainier School PAT C were in “immediate jeopardy” of harm from February to November 2020. Despite this danger, Washington State has not taken any action to close Rainier School PAT C or to move the 80+ residents to another service-setting without the constant risk of abuse, injury, and neglect.
Washington State Residential Habilitation Centers
Current ICF Census & Medicaid Certification Status

Fircrest PAT A
100+ Residents
Decertified 2017,
Brought Back Into Compliance 2018

Rainier School PAT A
Terminated

Rainier School PAT C
80+ Residents
Out of Compliance

Rainier PAT E
80+ Residents
Out of Compliance

Lakeland Village
90+ Residents
Out of Compliance

Total ICF Census: 372

Disability Rights Washington
Each state and territory has an independent advocacy organization with a federal mandate to monitor conditions of settings serving people with disabilities, investigate potential abuse and neglect of people with disabilities, inform people with disabilities about their rights, educate policy makers about the needs and rights of people with disabilities, and advocate to end rights violations, abuse, and neglect of people with
disabilities. In Washington, Disability Rights Washington is that organization as it has been designated as the state’s Protection and Advocacy System by the governor and funded to do this work by the U.S. Department of Health and Human Services.

Oversight Authority

The Centers for Medicare & Medicaid Services (CMS) is part of the U.S. Department of Health and Human Services, and is responsible for promulgating regulations about minimum standards of care in various licensed care settings and overseeing compliance with federal statutory and regulatory requirements for such facilities. Each state has an agency that conducts inspection and investigation surveys of private and state facilities on behalf of CMS. In Washington, Residential Care Services (RCS) is the state agency that conducts required inspections and surveys on behalf of CMS to license and certify long-term care facilities, including Residential Habilitation Centers. RCS conducts surveys of the RHCs at least every 15 months.

A window at Rainier School with flyers containing information about reporting abuse or neglect.
Generally, RCS submits a “Statement of Deficiencies” to a facility if a federal legal requirement, called a condition of participation, is not met. The facility responds with a “Plan of Correction” to address each and every legal violation. If the facility does not fix the unlawful conditions of care, RCS will send a letter to notify the facility of an enforcement action which can include a denial of payment for new admissions. If the facility continues to fail to meet minimum legal standards of safety and service delivery, RCS will then recommend to the state Medicaid agency that the facility’s certification and federal funding be terminated.

Scope and Methodology

The problems contained in this report are pulled directly from the surveys and findings of RCS, the state agency responsible for surveying Residential Habilitation Centers, from mid-2019 through early 2020. Throughout this report are references to the findings contained within Disability Rights Washington’s earlier reports on the RHCs. This report also includes information from earlier RCS surveys as well as news accounts, state policies, and federal and state law to provide context and explanation of the recent RCS findings.

Persistent Failures at RHCs Continue to Endanger Residents’ Lives

RHCs fail to provide needed medical care

Residential Habilitation Centers (RHCs) are required by federal law to ensure that residents receive routine and preventative medical care. In the recent past, each of the RHCs licensed as Intermediate Care Facilities
for people with Intellectual and Developmental Disabilities (ICFs) – Rainier School, Fircrest, and Lakeland Village – have failed to fully comply with the requirement to provide needed medical care. Residents went without dental exams\(^1\) and treatment,\(^2\) and annual vision and hearing screenings.\(^3\) A registered nurse at Lakeland Village even admitted that they did not have a process for following up on recommendations from community medical providers.\(^4\)

Washington’s RHCs have shown over and over again that when major problems are discovered, they do not act swiftly or make lasting changes that prevent future harm, even when failing to remedy legal violations costs lives. Despite being under the same Developmental Disabilities Administration (DDA) umbrella, a death at one RHC does not spark investigation and improvement of identical problems at another. In 2017, a resident returned to the Rainier School following an elective outpatient surgery. Rainier School did not incorporate post-surgical instructions into a
comprehensive plan of care and failed to recognize the resident’s shortness of breath as an indication of post-operative complications. The woman died several days later.\textsuperscript{15}

As a result of this death, RCS investigators cited Rainier School with an Immediate Jeopardy, a crisis situation in which the health and safety of residents is at serious risk. They categorized the institution’s failure as a systemic problem, not just an isolated event. They found Rainier School “failed to have a system in place to ensure appropriate follow-up medical care occurred for Clients returning from community medical providers. This failure put [the resident]… at risk of harm and may have potentially contributed to her death.”\textsuperscript{16} As part of their Plan of Correction, Rainier School updated its policies and re-trained staff to follow up on offsite medical procedures.

Yet, even after this woman’s death, another RHC persisted in similarly dangerous failures. In early June 2019 a Lakeland Village resident was hospitalized for a urinary tract infection, fever, and decreased oxygen levels in his blood. An infectious disease specialist prescribed a specific antibiotic to treat the infection and the resident was scheduled for surgery to place a urinary catheter. In the interim, the man returned to Lakeland where staff switched the antibiotic prescribed to him by an infectious disease specialist to a different antibiotic without any explanation or justification.\textsuperscript{17}

This unjustified change in antibiotic medication risked serious consequences. In early July, the resident had the outpatient surgery and
discharge instructions called for close monitoring of his symptoms. Just as with the Rainier School resident who died earlier, records show that Lakeland Village failed to write and implement a comprehensive plan to ensure staff knew how to properly care for the man after his surgery.\textsuperscript{18} Records show that over the next weeks, staff failed to monitor consistently or to appreciate obvious symptoms – even when the man cried in pain, saying his kidneys hurt. His condition deteriorated until he eventually refused to eat, drink, or take his medications.\textsuperscript{19} Finally, more than two months after his initial infection he was readmitted to the hospital. He had an infection along with dehydration and encephalopathy, a brain disease brought on by the infection.\textsuperscript{20}

Amidst his pain, discomfort, and encephalopathy, which can cause confusion and sudden changes in personality, the man became aggressive towards care workers. Hospital staff placed him in restraints to control his behavior and while he was restrained, found he had an unresolved fracture to his right arm.\textsuperscript{21}
RHC staffing model puts all residents in danger

Residents deliberately or accidentally leaving the facility, referred to as “elopement,” is something that occurs regularly at the RHCs. A resident might leave for the same reasons that anyone might take a walk – to leave an unpleasant situation or vent some emotional distress, to go to a place they enjoy to have fun or center themselves, to explore or satisfy a curiosity, or to break up the monotony of the day. Because it poses a risk to those individuals who may need support to exercise traffic safety or find their way back, elopement is something a facility must address in an individualized plan to help keep a resident who needs such supports safe. But such plans are useless if RHCs do not implement them.

On January 31, 2020, a resident left his RHC cottage without staff’s awareness and walked off into the winter night. A search of the vast wooded area surrounding the facility ensued. Three hours after he was last seen, police found the resident’s sweatshirt more than a mile from the facility grounds. As a winter storm brought heavy rains, gusting winds, and falling tree limbs, rescuers deemed it unsafe to continue searching that night. They resumed the search the next day, but after three unsuccessful days the search was called off. The man was never found.

This person’s disappearance was preventable. He had a behavior support plan that called for a staff member to follow him whenever he left the house. On the night of his disappearance, three staff members were scheduled to care for six residents. When two staffers took their breaks at the same time, they left only one staff member to care for those six people, all of whom could have required significant individual attention at any given moment.
RCS conducted an investigation of the disappearance and found Rainier School’s failure to ensure there were enough Direct Care Staff to provide for the supervision, protection, and care needs of all residents, in accordance with their individual program plans, posed an immediate jeopardy to residents’ safety. Over the next two weeks, Rainier School was given the opportunity to improve their staffing plans, but when RCS investigators returned, they found that Rainier School’s staffing plans still contained dangerous gaps. RCS conducted additional follow-up visits and found that the staffing problems persisted. Shockingly, RCS did not find that Rainier School had corrected the problem until November 2020 – after its failures led to the death of one resident, Rainier School kept the remaining residents at immediate risk of harm or death for over nine months.

The disappearance of the Rainier School resident was not the only event of its kind this year, or even that month. Just nine days earlier, another resident with a well-established history of elopement walked out of his
cottage and left the facility grounds. An off-duty staff member returning from lunch happened to spot him walking in heavy rain, without a coat, nearly a mile from campus. While the man was unharmed, the rural road had no sidewalks and only a chance encounter kept him from wandering further away. It is clear that Rainier School’s staffing model puts all residents at risk of harm, and for one man, had devastating consequences.

A problematic staffing model is not unique to Rainier School. Lakeland Village was cited for having insufficient Direct Care Staff to meet clients’ needs in November, 2018, January, 2019, and then again in June, 2019. This is a pervasive threat to residents’ safety and puts them at risk of neglect. It also harms quality of life. For instance, outings could frequently be cancelled due to inadequate staffing, depriving residents of experiences in the community. Inadequate staffing levels can also mean inadequate engagement of residents in the meaningful skill-building activities RHCs exist to provide.
RHC residents are still not safe from sexual abuse

In 2018, longtime Rainier School supervisor, Terry Wayne Shepard was convicted of attempted rape of one Rainier School resident and of taking “indecent liberties” with another. Shepard was sentenced to 24 ½ years to life in prison. Inexcusably, on the heels of Shepard’s conviction, Washington’s RHCs still fail to protect residents from sexual abuse.

Last year, a resident at Lakeland Village reported a sexual relationship with a staff member. DRW supports the rights of people with developmental and intellectual disabilities to have intimate relationships, but when a staff member has sexual contact with a resident, it is abuse and a criminal offense. Yet at the time of the resident’s report, Lakeland Village did not immediately act to prevent further abuse.

This year, another Lakeland Village resident reported that a prior community caregiver had an inappropriate sexual relationship with her and that the alleged perpetrator had been in contact with her while she lived at Lakeland Village. Again, Lakeland Village failed to protect the resident from further abuse. They documented no means of identifying the person and gave no instructions for staff to follow should the alleged perpetrator attempt to contact or visit the resident.

Similarly, the mother of a resident at Rainier School told staff that a family member may have been sexually abusing the resident. Rainier School made no plans to protect the resident should the alleged perpetrator...
attempt to visit. By failing to put any safeguards in place, both Rainier School and Lakeland Village left residents vulnerable to repeated abuse. The RHCs’ disregard for the seriousness of sexual violence must not be tolerated any longer.

RHC residents experience physical abuse at the hands of staff

In 2019, people with developmental disabilities living in Washington’s institutions were victims of violence at the hands of RHC staff. A Lakeland Village employee admitted he kicked a resident in the chest, causing him to hit the wall and fall to the floor. He stated that this was because the resident had urinated on his bed sheets. This incident occurred in full view of other staff who then stood by as the abuser walked over to the resident he kicked to the floor and rubbed the urine-soaked sheet in his face. No staff protected the resident as he lay on the floor and no staff intervened to immediately rebuke these actions. In fact it took four hours for the witnessing staff member to report the assault to administration.

In another incident, a Fircrest staff member was alone with a resident in his room for two minutes. When the resident emerged, he had a mark under his eye and reported that the staff member had hit him. Over several days the resident told at least four different Fircrest employees, including a manager and nurse, that the staff member had hit him. No one at Fircrest reported the incident to law enforcement or to the State Complaint Resolution Unit, in violation of mandatory reporting requirements. While they investigated the incident internally, Fircrest failed to protect other residents from the allegedly abusive staff member. They simply assigned him to serve residents in another part of the same house.
These failures perpetuate a culture where staff abuse or mistreatment of residents is not taken seriously. Again and again, RHCs fail to prioritize residents’ wellbeing and fail to hold staff accountable for harm.

**RHCs still do not deliver the services they exist to provide**

RHCs have a mandate to support individuals in achieving their highest level of abilities through a comprehensive educational program known as active treatment. Active treatment is a coordinated program that includes specialized training, treatment, and health services to help each person with a developmental disability to live with as much self-determination and independence as possible.

As RHCs face the loss of federal funding due to noncompliance with minimum federal standards of care, DSHS representatives have tended to focus the blame on CMS, claiming that their standards are overly burdensome even though these are the same legal standards applied in and met by public and private facilities across the entire nation every day. When Lakeland Village was put in a denial of payment status by the state’s Medicaid agency last fall, a DSHS spokesperson explained the action to a local newspaper by saying “Surveyors came down and saw some things they didn’t like…. If surveyors see someone has been sitting there for too long and they don’t see them getting active treatment, then they ding us for it.”

Last year a workgroup was convened to report to the legislature on how to better provide services for individuals currently living in RHCs. They concluded: “state-run ICFs continue to face considerable risk of federal divestment. At the heart of this risk are issues related to federal active treatment requirements. The demanding nature of these federal
requirements has resulted in citations for gaps in active treatment as short as 20 minutes.\textsuperscript{41}

This framing makes it sound as though the federal regulators threaten to revoke millions of dollars in funding from Washington’s RHCs over minor technicalities, suggesting tiny breaks in an otherwise continuous regiment of effective programming. It sweeps the numerous citations for failures to comply with other Medicaid Conditions of Participation under the rug – conditions that jeopardize people’s health, safety and even their lives.

Further, active treatment citations are not just about short breaks between activities. In the past year, RCS has cited RHCs for failures at every conceivable step in the active treatment process.

- RHCs fail to assess residents’ needs;
- RHCs assess residents’ need, but fail to write any plan to address those needs;
- RHCs write treatment plans, but fail to make them clear enough for staff to know how to implement;
• RHCs fail to implement treatment plans correctly;

• RHCs fail to implement treatment plans consistently;

• RHCs fail to keep adequate records to track residents' progress;

• RHCs fail to recalibrate treatment goals when resident progress is slow;

• RHCs fail to advance treatment goals when residents master target skills;

• RHCs blame residents' behaviors for preventing active treatment; and

• RHCs fail to provide supports to address communication barriers or behaviors impeding other active treatment.

The DSHS spokesperson's cavalier dismissal of active treatment citations minimizes the RHCs' responsibility to fulfill their federally and state mandated purpose. People with developmental disabilities who live in RHCs trade a life in the community for the promise of robust supports and treatment. By chalkling up deficiencies as regulatory “dings” the state grossly misrepresents RHCs’ abysmal failure to deliver on that promise.

**RHCs and the Threat of Coronavirus**

In 2020, residents in RHCs and in all congregate care settings face a new danger: coronavirus and its associated disease, COVID-19. It has long been the case that institutions create conditions ripe for the spread of contagious disease. This year that stark reality came sharply into focus. As of October 30, 2020, COVID-19 infections connected to long-term care settings accounted for nearly 10% of Washington’s cases and staggeringly
over half of COVID-related deaths. It has never been clearer that institutional settings are simply not safe.

The danger of infectious disease transmission in congregate care settings is not at all new. Facility-acquired infections are common, including at RHCs. Last year at Lakeland Village, a man was diagnosed with an infection from a particular drug-resistant e-coli bacteria. Days later, one of his housemates was diagnosed with an infection from the same e-coli. The facility recognized that the second man’s infection may have been due to cross-contamination by staff. Yet they responded inadequately. Lakeland Village held an in-service training for Licensed Nurses to refresh their knowledge of infection control protocols. They did not, however, deliver the same training to Direct Care Staff.

At Rainier School, a lab technician conducted blood draws without changing gloves between patients. The technician’s actions put people at risk for cross-contamination of skin infections and blood borne pathogens. The technician admitted to the RCS survey who observed this that he knew the policy was to change gloves, but said he did not follow the policy because he thought it took too long. The RHC re-trained the technician on safety procedures but did nothing to address the disregard for residents’ safety or to monitor his future compliance with infection control protocols.

RHCs have demonstrated a poor track record for infection control at every level – from direct care and medical staff to leadership. In the current COVID-19 crisis, these institutions cannot be relied upon to prevent residents from contracting a potentially deadly disease.
There is a better way

With the closure of Rainier School PAT A, DSHS was able to move over half of its residents out of RHCs and into smaller supported living settings or Adult Family Homes in the community—and they did so in a relatively short time period. Gregory Paul moved to Rainier School in 1964 when he was 12 years old. After 55 years his family could not imagine another possibility. But when PAT A closed, he moved to a home in a suburban neighborhood with his best friend and two other former Rainier School residents. The home is one of several in the State Operated Living Alternative (SOLA) program, which provides intensive around-the-clock supports delivered in homes to 1-4 residents. SOLAs have worked for many who left Rainier School PAT A and could work for the other residents still held in the RHCs.

A legislative workgroup described the closure of Rainier School PAT A as a success and credited the expansion of SOLA as a key factor. SOLA may be just one piece in a broader approach to helping all people with developmental disabilities to live and enjoy life as integrated members of the community, but it shows it can and does work. Mr. Paul’s story illustrates that the State’s failures in moving people out of the RHCs are not because it is impossible. Instead, it is because of a lack of leadership and a general unwillingness to transition people from the outdated and poorly-managed RHCs to settings that can meet each person’s individual needs in the community.
Conclusion

With the threats that RHC residents now face from inadequate care, abusive staff, and COVID-19, along with the threat of lost federal funding resulting from the RHCs “chaotic” and “dangerous” mismanagement, it is imperative that the State stop pursuing Band-Aid fixes and work swiftly to find sufficient, sustainable solutions. RHCs have bred abuse and neglect and failed to promote either safety or skill development for far too long. They should be closed over a specific, sensible period of time to allow for safe transition to individually tailored supports in smaller settings that allow for more individualized attention and accountability.

To best understand appropriate community supports, it is imperative that the State involve people with intellectual and developmental disabilities in the decision making around these systems of support. As of 2016, 15 states have eliminated all public institutions that seclude people with intellectual and developmental disabilities. Washington must look to these states for guidance. More importantly, the State must look to the people most impacted for leadership.

“Nothing about us without us” has been the clear message from self-advocates for years. People with developmental and intellectual disabilities, both in and out of RHCs, are experts on their own lives and the State has demonstrated they need some expert advice. Disability Rights Washington recommends State policy makers humbly ask for this expert advice, fund it, and follow it in order to build a system that truly meets the needs of Washingtonians with intellectual and developmental disabilities.
About the authors

Colleen Caffrey joined Disability Rights Washington in May, 2020, as part of the Investigation and Accountability team. She previously worked in administrative and financial management roles for the Statewide Independent Living Council of Georgia and other non-profit organizations.

Colleen is a graduate of Cornell University with a B.S. in Human Development and Family Studies. She has worked as a music educator, teaching preschoolers and retirees to drum. She is a passionate volunteer with the Girls Rock Camp network, empowering girls, women, trans and gender-expansive people through creative self-expression and collaboration.

Beth Leonard joined the Treatment Facilities Team in October 2019. She is a passionate advocate for justice who has focused her legal career working on behalf of low-income and marginalized communities. She worked as a staff attorney at Legal Action Center providing eviction defense services to low-income tenants in King County and most recently, as a Regional Developmental Disabilities Ombuds / Legal Counsel for the Office of Developmental Disability Ombuds. She also served as Washington State’s first Pro Bono Council Manager where she provided coordinated support and advocacy to Washington’s 17 Volunteer Lawyer Programs. Beth is an adjunct professor at Seattle University and a graduate of Washington’s JustLead Leadership Academy. Beth graduated cum laude from Seattle University School of Law where she was chosen by faculty as the Law Faculty Trust Scholar for the class of 2013.
**End Notes**


5 See CENTERS FOR MEDICARE & MEDICAID SERVS., QUALITY, SAFETY & OVERSIGHT, [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/index.html) (last visited July 10, 2020) (stating “CMS maintains oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers […] The survey (inspection) for this determination is done on behalf of CMS by the individual State Survey Agencies. The functions the state performs for CMS under the agreements in Section 1864 of the Social Security Act (the Act) are referred to collectively as the certification process.”).

6 See WASH. STATE DEP’T OF SOC. & HEALTH SERVS., RESIDENTIAL CARE SERVS., [https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services](https://www.dshs.wa.gov/altsa/residential-care-services/residential-care-services) (last visited July 10, 2020) (stating “RCS is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and certified community residential services and supports.”).


9 See 42 C.F.R. § 442.118; see also, e.g. supra note 3.

10 See 42 C.F.R. § 483.460(a)(3).


16 Id. at 1-2 (finding violation W149 citing 42 C.F.R. § 483.420(d)(1)).

17 Supra, note 14 at 74-75 (finding violation W322 citing 42 C.F.R. § 483.460(a)(3)).

18 Id. at 76.

19 Id. at 82-84 (finding violation W339 citing 42 C.F.R. § 483.460(c)(4)).

20 Id. at 72 (finding violation W320 citing 42 C.F.R. § 483.460(a)(2)).

21 Id. at 72-73. There was no additional investigation into when or how that fracture occurred or how long Lakeland Village may have let the man suffer with an undetected fracture on top of the pain from his uncontrolled infection.


25 Supra, note 22 at 3-9 (finding violation W186 citing 42 C.F.R. § 483.430(d)(1-2)).


28 Supra, note 12 at 11-13 (finding violation W127 citing 42 C.F.R. § 483.420(a)(5)). Rainier conducted a required 5-day investigation into the incident. The man had a history of eloping and an individualized behavior support plan requiring staff to accompany him and keep him in sight when he left the house. On the day he was discovered off campus, staff at his house didn’t realize he had left. The investigation noted that the facility had listed minimum care requirements for the man’s house as seven staff members. That day there were only five. Rainier’s internal investigation made no recommendations for changes to policy or practice that might guard against future elopement incidents. And so under similar circumstances nine days later, another resident of Rainier School disappeared and was never seen again.

30 DDA policy makes clear that any sexual contact of a resident by a staff member constitutes abuse. DDA Administrative Policy 5.13, *Protection from Abuse: Mandatory Reporting*. Washington State law defines sexual contact by a person in a position of supervisory authority over a victim with a developmental disability as a crime—either rape in the 2nd degree, RCW 9A.44.050, or the lessor sexual offense, indecent liberties, RCW 9A.44.100.

31 RCS SOD for survey dated 7/9/19, Lakeland Village, 7-9 (finding violation W155 citing 42 C.F.R. § 483.420(d)(3)), [https://fortress.wa.gov/dshs/adssaapps/lookup/RCSSforms/ICFIID/120/investigation/2019/R%20LAKELAND%20VILL AGE%20JXC911%20complaint%2007-09-2019%20-%20cc.pdf](https://fortress.wa.gov/dshs/adssaapps/lookup/RCSSforms/ICFIID/120/investigation/2019/R%20LAKELAND%20VILL AGE%20JXC911%20complaint%2007-09-2019%20-%20cc.pdf). Lakeland Village moved the staff member to another cottage where he still had access to other residents and then reassigned him to a position away from residents the following day. They did not complete a required internal investigation to determine whether the allegation was true and if so, what circumstances allowed it to occur or what could be done to prevent abuse in the future.


33 *Supra*, note 12 at 9-11 (finding violation W127 citing 42 C.F.R. § 483.420(a)(5)).

34 *Supra*, note 32 at 1-3.

35 *Id.* at 4-6 (finding violation W153 citing 42 C.F.R. § 483.420(d)(2)).


37 *Id.* at 5-6 (finding violation W155, *citing* 42 C.F.R. § 483.420(d)(3)).

38 Under federal law, ICFs must provide active treatment, which is defined as “a continuous...program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services...that is directed toward...[t]he acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible...” 42 C.F.R. § 483.440(a)(1).

39 *Id.*


43 *Supra*, note 14 at 78.


46 *Supra*, note 41 at 8.

47 *Supra*, note 2.