STATE OF WASHINGTON

DEPARTMENT OF HEALTH

NOTICE OF IMMEDIATE ENFORCEMENT ACTION

November 26, 2024

Rainier Recovery Center LLC
3214 50th St. Ct. Ste 305
Gig Harbor, WA 98335-8587

License No: BHA.FS.61436722-BRNCH

Re: Investigation Nos. 2024-6862 and 2024-13470

Master Case No. **M2024-945.**

Dear Licensee:

This is a notice of **SUSPENSION** of the license for your behavioral health agency, Rainier Recovery Center LLC (Rainier Recovery) – BHA.FS.61436722-BRNCH, located at 3214 50th St Ct Ste 305, Gig Harbor, WA 98335-8587 pursuant to Chapters: 71.24 RCW.

The suspension is effective immediately upon receipt of this notice.

However, the **SUSPENSION** shall immediately be stayed until 5p.m. on December 2, 2024.

During the stay, Rainier Recovery – BHA.FS.61436722 shall comply with the following:

A. Stop all admissions of new patients.

B. Safely and appropriately discharge or transfer all current patients of Rainier Recovery.

C. Within the first twenty-four (24) hours of the stay, Rainier Recovery shall develop and provide a "Closure Plan" via email to Ian Corbridge, Director, Office of Community Health Systems, (ian.corbridge@doh.wa.gov). The "Closure Plan" must contain the following elements:

i. Information pertaining to the patient census, acuity (deidentified information on primary diagnosis), and payor mix in table format on the calendar day in which the suspension becomes effective;

ii. A plan for referring patients ("Closure Transfer Plan") to appropriate care settings that offer similar services or services mandated based on court documents. The

"Closure Transfer Plan" must take into consideration the most appropriate setting possible in terms of quality, services, and location, as available and determined appropriate by the patient care team after taking into consideration the patient's individual needs, choices, and interests;

iii. A plan for notifying patients, patient guardians, patient families, any surrogate decision makers of the patient, and insurance company (if applicable) of the license suspensions; and

iv. A plan for notifying the courts of the license suspensions.

D. By 5p.m. on December 2, 2024, Rainier Recovery shall provide a formal letter via email to Ian Corbridge, Director, Office of Community Health Systems, Ian.Corbridge@doh.wa.gov affirming the "Closure Plan" has been fully executed. If any part of the closure plan has not been fully executed, Rainier Recovery shall identify such elements and steps taken to address the requirement of the "Closure Plan".

Basis for the suspension:

During the course of the above referenced investigation at Rainier Recovery, the Department of Health, Office of Health Systems Oversight (Department) found deficient practices or conditions more fully described below that constitute an immediate jeopardy.

A. Findings of Fact

1.1 Rainier Recovery is owned by Rainier Recovery Centers LLC (UBI # 605 025 915). Rainier Recovery Centers LLC also owns and operates other behavioral health agencies, including facilities in Puyallup (BHA.FS.61506126-BRNCH) and Gig Harbor (BHA.FS.61436722-BRNCH). The sole governing person of Rainier Recovery Centers LLC is Staff A, who is also the CEO. All three (3) facilities also share the same Administrator.

Administrator Key Responsibilities, Agency Staff Requirements, Certification of Substance Use Disorder Professional Trainee

1.2 Rainier Recovery, and its Administrator, has systematically failed in its' obligation and responsibilities towards ensuring staff providing substance use disorder services are properly trained, educated, qualified, instructed and supervised as demonstrated by the following.

//

//

Interviews

1.3 On June 5, 2024, a Department representative interviewed Staff D, SUDPT. During the interview, Staff D reported, among other things, the following information:

A. Staff A, SUDP and CEO, was in-charge and made all the decisions at Rainier Recovery.

B. Staff D was hired to be the Operations Director at Rainier Recovery but stepped down because they felt Staff A was going to scapegoat them and put them in a position to be the frontline defense for any Department investigation and audit.

C. Staff D was training people, including other SUDPTs.

D. Staff D would send assessments and treatment plans to Staff A for approval, and Staff A would approve everything "right away". Staff D did not know if Staff A took the time to read the assessments and treatment plans.

1.4 On June 7, 2024, a Department representative interviewed Staff U, SUDPT. During the interview Staff U reported, among other things, the following information:

A. Staff A told Staff U they could apply to an SUDPT credential and then had two (2) years to enroll in an educational program.

B. Staff U did not receive any supervision while practicing as an SUDPT at Rainier Recovery.

C. Staff U's first fifty (50) hours of face-to-face patient contact was not supervised. Staff A was not physically present for this time and was only available by phone or email.

D. Staff U worked mostly independently and without clinical supervision.

E. Review of the personnel file for Staff U, SUDPT, showed a document titled “[Employment Application]”. The application showed Staff U applied for a position as “Peer Support Counselor” with the agency on March 15, 2023. The application showed Staff U had no prior training or education working in a clinical setting or providing services to individuals with mental health or substance use disorders.

F. Review of the Integrated Licensing & Regulatory System (ILRS) showed that Staff U applied for their SUDPT credential to the DOH on March 15, 2023. Staff U’s application included an attestation made by Staff U, under penalty of perjury, that Staff U was obtaining the education and experience required to receive a Substance use Disorder Professional credential.

1.5 On June 10, 2024, a Department representative interviewed Staff V. During the interview Staff V reported, among other things, the following information:

A. A number of Rainier Recovery's employees have licenses that are invalid, or they do not have a license at all.

B. A number of Rainier Recovery's employees "think they are SUDPTs but they are not properly trained or educated, and have not enrolled in school."

C. A number of Rainier Recovery's employees thought they were practicing as SUDPTs correctly because Staff A told them that they were.

D. Some staff lost a lot of SUDP/SUDPT experience hours because there was no one providing clinical supervision to sign-off on their experience hours.

1.6 In addition, during an interview between a Department representative and Staff V on June 10, 2024, the following was disclosed about Staff A, Patient 18, and Patient 18's ex-girlfriend:

A. Staff V received a phone call from Staff D. Staff D reported to Staff V that Patient 18 had disclosed to Staff D that Patient 18's ex-girlfriend had told Patient 18 that she had been sexually abused by Staff A.

B. Staff D held on to the information reported by Patient 18 because they did not know what to do, and were afraid that if they put that information in Patient 18's clinical record they could be fired. After Patient 18 disclosed this information to Staff D, Patient 18's ex-girlfriend died by suicide.

1.7 Rainier Recovery's clinical records for Patient 18 did not contain any reference of the allegation reported by Patient 18 to Staff D, or that it was reported by Rainier Recovery to the Department or other state agency.

1.8 A review of records provided by the Department of Children, Youth and Families did demonstrate that an employee reported the allegation on May 29, 2024.

1.9 On June 18, 2024, a Department representative interviewed Staff W, SUDPT. During the interview Staff W reported, among other things, the following information:

A. Staff W was supervised by Staff S, SUDP Clinical Director, but that Staff A signed off on Staff W's experience hours.

B. When Staff S resigned around April 2024, Staff A was the only SUDP supervising more than ten SUDPTs at Rainier Recovery's three (3) locations.

1.10 On June 21, 2024, a Department representative interviewed Staff X, SUDPT. During the interview Staff X reported, among other things, the following information:

A. Staff X had a certified peer counselor credential when they were hired by Rainier Recovery and applied for an SUDPT credential once hired by Rainier Recovery.

B. Staff X applied for their SUDPT credential because Staff A told Staff X that Staff X would have time to go to an educational program. Staff X told Staff A they did not feel like they had time to attend an educational program.

C. Staff A assured Staff X that Staff X could conduct assessments and provide other SUD services as an SUDPT as soon as Staff X's application had been submitted and before the application had been approved by the Department.

D. Staff X observed a number of employees at Rainier Recovery submit an application to be credentialed as an SUDPT and then begin conducting assessments and SUD treatment services before the application had been approved by the Department.

E. Staff A submitted Staff X's application for an SUDPT credential on Staff X's behalf. Staff A also paid the application fee for Staff X.

1.11 On July 24, 2024, a Department representative interviewed Staff Z, SUDPT. During the interview Staff Z reported, among other things, the following information:

A. Staff S was Staff Z's official supervisor but was frequently not present due to family issues, which meant Staff F was the person put in-charge of training and supervising Staff Z.

B. During a counseling session, Staff Z observed Staff Z assisting a patient fill out child custody court documents.

C. Staff F would ask Staff Z to change assessments, which would sometimes result in Staff F taking over the assessment process, changing the assessment, and then completing the assessment.

1.12 On July 24, 2024, a Department representative interviewed Staff AA, SUDPT and Mental Health Counselor Associate (MHCA). During the interview Staff AA reported, among other things, the following information:

A. Many of the staff were not qualified or trained properly.

B. Staff at Rainier Recovery would need Staff A's final approval when reports were written to be sent to the courts. Staff AA would get in trouble with Staff A for being accurate in these reports.

C. Many staff at Rainier Recovery were working in roles as SUDPTs but were not receiving proper training or supervision and were not seeking the required education.

1.13 On July 25, 2024, a Department representative interviewed Staff BB, SUDPT. During the interview Staff BB reported, among other things, that one of the three (3) Rainier Recovery locations did not have an SUDP physically available for the duration of Staff BB's employment (approximately September 2023 through February 2024), which meant the location was physically staffed by SUDPTs only.

1.14 On August 6, 2024, a Department representative interviewed Staff B, Clinical Director. During the interview Staff B reported, among other things, that prior to Staff B's hire date on June 24, 2024, Rainier Recovery had no documentation of supervision activities or supervision hours, and that Staff A was responsible for that. Staff B also stated that they anticipated Rainier Recovery could be fined as part of the investigation, and that Staff A may lose their license because SUDPTs have been allowed to operate without proper supervision.

Record Review

1.15 Review of the SUDPT personnel files for Staff F, I, J, G, H, Z, R, and BB provided by the agency to DOH on August 2, 2024, showed that none of the files contained clinical supervision documents or documentation of accrued supervision hours. The personnel files did not contain signed position descriptions; orientation records that included the agencies policies and procedures or the process for resolving patient concerns; documentation of cultural competency or violence prevention training; documentation of staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities; or documentation of training on the prevention and control of communicable diseases, bloodborne pathogens, and tuberculosis. The review showed that the records provided did not contain documentation of new employee training or recurring annual trainings.

1.16 Review of Patient 14’s clinical record showed that the agency failed to ensure that staff providing services to Patient 14 conducted an assessment of presenting issues and that their assessment was updated to reflect changes to the patient’s overall condition; evaluated the patient for risk; issued treatment recommendations and treatment plans that were based on the assessment; updated the assessment based on changes to the patient’s

overall condition; used DSM-5 diagnostic criteria and guidelines; and used ASAM criteria to determine the most appropriate placement decision and the patients' individual need for substance use disorder services as evidenced by:

A. Review of the clinical record for Patient 14 showed a document titled "Adult Psychosocial Assessment", dated April 15, 2023. It showed that during Patient 14's assessment, Patient 14 denied mental health issues or receiving treatment for their mental health. The assessment contained one-word answers to questions that required narrative responses. The assessment showed that Patient 14's legal history included a DUI and that their Blood Alcohol Level (BAL) at the time of arrest was .112. The assessment showed that the overall level of care recommendations was an ASAM level 0.5, No Significant Problem (NSP), justified by "Client does not meet the criteria for a substance use disorder at this time". Review of the assessment showed that Staff F, SUDPT, did not gather sufficient information to determine the correct ASAM level of care for Patient 14. The assessment was signed by Staff F, SUDPT on April 18, 2023 and Staff A, CEO and SUDP, on April 19, 2023.

B. Review of Patient 14's clinical record showed a document titled "DOL Discovery", dated June 5, 2023. The document included copies of the DUI arrest report, dated March 14, 2023, which showed that at the time of arrest, Patient 14 endorsed taking prescribed medication for depression. Review of Patient 14's clinical record showed that it did not contain documentation of treatment interventions between April 15, 2023 until January 21, 2024, approximately nine (9) months.

C. Review of Patient 14's clinical record showed a document titled, "Alcohol and Drug Information School Completion", dated January 21, 2024. The "Alcohol and Drug Information School Completion" indicated Patient 14 completed ADIS on January 21, 2024.

D. Review of Patient 14's clinical record showed a document titled "Treatment Plan", dated February 10, 2024. The "Treatment Plan" contained the following:

   i. Patient 14 was in "Extended ADIS + three (3) months monthly monitoring".
   ii. Patient 14's Level of Care (LOC) was "Puyallup", which is an undefined level of care.
   iii. Patient 14's duration of services was three (3) months.
   iv. Patient 14's legal requirements were "Negligent driving".

v. Dimension 4 - Readiness for Change's problem statement showed Patient 14 endorsed, “I self-medicate, and I know I need to get my bipolar diagnosed.”

vi. Dimension 5 - Relapse, Continued Use, or Continued Problem Potential's problem statement showed Patient 14 endorsed “I drink because I have switched from heroin to alcohol.”

vii. The treatment plan was signed by Staff F, SUDPT on February 10, 2024 and did not contain a supervising SUDP signature.

viii. The treatment plan did not correspond with the initial assessment and recommendations that was conducted on April 15, 2023. No other assessment was contained in the Patient 14's clinical record.

E. Review of Patient 14’s clinical record contained a document titled “Session Note”, dated February 17, 2024. The “Session Note” indicated Patient 14's primary diagnosis as Z03.89, which represents an encounter where a patient was observed due to a suspicion of a particular disease or condition, but after examination, this was ruled out. The “Session Note” showed that "Level 1 Outpatient" treatment was marked as “inactive”. The “Session Note” also showed, “… [Patient 14] was confused if [they] needed to do groups or not…[their] counselor let [them] know what steps [Patient 14] needs to take to be completed with treatment”. The “Session Note” also showed that Patient 14’s goal was “Do what I have to do to get on medication, so I do not have to self-medicate… abstain from alcohol.”

F. Review of an email exchange between Investigator 1 and the Pierce County District Court showed “[Patient 14] had a Date of Death (DOD) of February 23, 2024.”

G. Review of the Pierce County Medical Examiner’s report, signed April 3, 2024, showed that Patient 14 died from acute intoxication with fentanyl. It showed that Patient 14 had additional substances, including Benzodiazepines, in their system when they died.

H. Review of Patient 14’s clinical record showed a document titled “Monthly Progress Report”, dated February 29, 2024. It showed that Patient 14 attended two (2) of three (3) scheduled sessions in February of 2024. It showed that they completed one UA, collected on February 17, 2024, that tested negative for substances. It showed, “[Patient 14] will be required to

complete six (6) months of outpatient services".

I. Review of Patient 14's clinical record showed a document titled "Client Treatment History", undated. It showed that on March 6, 2024, Patient 14 was discharged for an unspecified reason.

Individual Service Record Content, Behavioral Health Outpatient Intervention, Assessment and Treatment Services – Certification Standards

1.17 Rainier Recovery consistently failed to ensure clinical records were accurate and met minimum requirements as demonstrated by the following.

Interviews

1.18 On June 7, 2024, a Department representative interviewed Staff U, SUDPT. During the interview, Staff U reported, among other things, the following information:

A. Staff U stated, "I did things that I am not proud of." Staff U explained that Staff A incentivized them to collect late payments from patients by promising to increase employee salary in return.

B. Staff U stated that "[Staff A] is in with the attorneys." Staff U further elaborated that Staff A had favorite attorneys who they were "really tied in" with, and that these attorneys' clients, who were patients at Rainier Recovery, always had priority.

C. When asked if Staff U was ever directed to do things differently for those patients, they stated that "sometimes the level of care would be changed according to what [Staff A] wanted, to make the attorney happy."

D. After Staff U would complete an assessment, they would send it to Staff A. Staff A would review the assessment and send it back to Staff U and tell them to change the assessment to a lower level.

E. Staff U completed an assessment for a patient who was on court probation supervision with Staff A's fiancé, Individual 3. Staff U submitted this assessment to Staff A for review. Staff A changed the "date of last use" on the assessment from what Staff U had originally entered. Staff U stated that Staff A was the only one who could have made that change, although Staff U signed the assessment.

F. When asked if Staff A regularly makes changes like this, Staff U stated that "doctoring the assessment" appeared to be isolated, but "having me change the recommendation" was a pattern. Staff U stated that Staff A would justify the changes by saying that they "had to keep the attorneys happy."

1.19 On June 21, 2024, a Department representative interviewed Staff X, SUDPT. During the interview, Staff X reported, among other things, the following information:

A. Staff X stated that they were concerned about unethical or unprofessional practice at Rainier Recovery.

B. Staff X stated that there was a particular attorney from a law firm who would call Staff A and direct Staff A to change patients' assessment results and level of care. Staff X further explained that Staff A would ensure that patient level of care would be changed "down to the bare minimum from needing a higher level of care," pursuant to the attorney's direction.

C. Staff X stated that Staff U and Staff W, both SUDPTs, have been told by Staff A to change patient assessment results and level of care.

1.20 On July 24, 2024, a Department representative interviewed Staff AA, MHCA and SUDPT. During the interview, Staff T reported, among other things, the following information:

A. Staff AA stated that drug testing and compliance reporting were not done properly. Staff AA elaborated that staff would falsify urinalysis (UA) testing results and change results in patient clinical records. Staff would remove positive UAs from the fridge so they would never be sent out for further testing. When this would occur, patient charts would be marked with a negative UA result.

B. Staff AA stated that Staff D, SUDPT, would engage in the above conduct. Staff D jokingly asked Staff AA why all they patients "always tested positive."

C. Staff AA stated there were things they weren't allowed to report to the courts, including when patients missed appointments or when they had positive UAs. If Staff AA tried to accurately report UA results and compliance issues to the court, they would get in a lot of trouble. Staff AA stated they tried to make accurate reports to the courts but that Staff A "had the last say." This issue arose several times and Staff AA was eventually fired without being given a reason.

D. Staff AA stated that on one occasion, a patient tested positive for fentanyl and their positive test result was changed to a negative test result in the patient's file. Staff AA further stated that they were providing mental health counseling to another patient and based on what the patient spoke about in their session, they had serious concerns that the patient would overdose on fentanyl. Staff AA was concerned that Respondent's practices would place this patient at further risk.

E. Staff AA stated that the owner, Staff A, ran the agency in a way that generated maximum revenue. Staff AA further provided that when patients were not compliant or relapsed, accurate reporting to the courts about noncompliance or relapse would compromise the revenue the agency could generate from those patients.

F. Staff AA stated that there was a law firm that worked closely with Staff A, and that Staff A had a "deal" with the attorney running that firm. Staff AA stated that the attorney would send their clients to Respondent, so long as Staff A ensured that those clients met all their conditions and were compliant. Staff AA stated that this arrangement would give the law firm better success rates and make them popular with patients, while also ensuring that Staff A had guaranteed revenue through patient admissions.

G. Staff AA stated that group sizes were very large and that the large group sizes were intentional to ensure that the agency got the maximum amount of revenue for patients paying for group participation.

H. Staff AA stated that some patients would refuse to provide UAs and that their counselors would say that the refusal was "fine" and the patients didn't have to submit a UA.

1.21 On July 25, 2024, a Department representative interviewed Staff BB, SUDPT. During the interview, Staff T reported, among other things, the following information:

A. Staff BB stated that agency staff had problems with ethical and professional.

B. Staff BB stated they were aware that agency staff would change patient recommendations at the direction of a particular law firm. Staff BB further provided that the agency would take on the law firm's clients as patients and that there was an arrangement between the agency and law firm to ensure that patients were "stepped down" in their assessments and level of care.

C. Staff BB stated that Staff F and Staff G were blatant about changing assessment results. Staff F asked Staff BB to change assessments, but Staff BB refused.

D. On one occasion, Staff BB completed an assessment for a patient. The patient was then transferred to a different counselor, Staff GG, SUDPT. Staff GG asked staff BB to remove relevant information from their assessment. Staff BB refused. Staff GG then deleted portions of Staff BB's assessment, changed the information in the patient's electronic health record (EHR), and billed the patient for a second assessment which Staff GG completed, omitting the relevant information.

1.22 On July 24, 2024, a Department representative interviewed Staff Z, SUDPT. During the interview, Staff Z reported that Staff F would ask them to change assessments. Staff Z would begin the assessment, but then Staff F would "take over," change the assessments, and complete them on Staff Z's behalf.

Record Review

1.23 Review of Patient 1's clinical record demonstrated:

A. Patient 1 was charged with a DUI that was reduced to reckless driving. This information was found in one of Patient 1's treatment plans, as their clinical record did not contain any court records including a copy of the court order.

B. Patient 1's clinical record included a section titled "Lab Test Results" that contained nine (9) urinalysis test results ranging from February 2024 to July 2024. One of the urinalysis test results that was reported on April 25, 2024, indicated a positive result for Dextromethorphan and Levorphanol (cough syrup and metabolites). The urinalysis test result shows that no active prescriptions were reported for Patient 1 to the testing laboratory for dextromethorphan.

C. Review of a document titled "Monthly Report", dated April 30, 2024, showed "[Patient 1] had a positive urinalysis test, upon further review it was for substances found in cough syrup and was an amount that is consistent with responsible use." Patient 1 was marked in full compliance for the monitoring period. This report was not flagged for noncompliance.

1.24 Review of Patient 3's clinical record demonstrated the following:

A. Patient 3's clinical record contained a document titled "DUI Arrest Report", dated December 10, 2023. It showed that after a traffic collision Patient 3 was arrested for DUI and that their blood alcohol content (BAC) that was obtained approximately one (1) hour after their arrest was .176.

B. Review of a document titled "Adult Psychosocial Assessment," dated January 5, 2024, revealed that Patient 3 reported their last use date as December 30, 2023, and that they endorsed drinking alcohol. During their assessment, Patient 3 endorsed drinking around eighty-four (84) glasses of wine a month, for the last three (3) to twelve (12) months, and having driven under the influence approximately twelve (12) times in the last year. Patient 3 endorsed seeking treatment prior to their most recent DUI and being able to stay sober for about five (5) weeks. The assessment states that Patient 3 was diagnosed with F10.20, alcohol dependence, uncomplicated. "Alcohol dependence, uncomplicated" is not a recognized DSM5 diagnosis criterion. According to the DSM5, the diagnostic criteria should indicate either mild,

moderate, or severe alcohol dependence. Based on the DSM5 diagnostic criteria, it was not clear why the patient was not listed as "severe" for alcohol use disorder. The assessment indicated the overall level of care recommendation was at an ASAM level 1.0, and further provided that this level of care was justified because “[Patient 3] meets criteria based on [their] lack of coping skills and education on the disease of addiction. [Patient 3] is unaware of the negative impact [their] continued use could have on their life. [Patient 3] has trauma that has never been addressed and could potentially lead to relapse”. The assessment was signed by Staff F, SUDPT and by Staff A, CEO and SUDP on January 6, 2024. The level of care recommendation is not consistent with the patient history of alcohol use and the patient meeting seven (7) of the DSM5 diagnosis criteria for meeting severe alcohol use disorder.

C. Review of Patient 3’s record showed there were five (5) treatment plans, dated January 5, 2024; January 16, 2024; March 19, 2024; May 14, 2024; and August 1, 2024. Of all treatment plans reviewed, one treatment plan dated August 1, 2024 identified target dates for achieving treatment goals. The treatment plans dated January 5, 2024 and January 16, 2024 showed they were prepared and approved by Staff F, SUDPT and did not contain a supervising SUDP signature. Treatment plans were incomplete, did not contain measurable goals, interventions and objectives, and did not have SUDP approval.

D. Review of the document titled “Monthly Compliance Report”, dated May 31, 2024, showed Patient ’s treatment activity for the month of May. It showed the date of enrollment as January 5, 2024. It showed that Patient 3 was excused for five (5) outpatient telehealth sessions and that they missed one (1) outpatient session and one (1) appointment for a therapeutic injection. It showed that Patient 3 submitted a UA on May 8, 2024, for Medication Assisted Therapy (MAT) services, and one (1) on May 28, 2024, that was positive for prescribed medications. It showed Patient 3 was marked to be “in full compliance”. It showed, “[Patient 3] continues to do great in groups and one-on- ones. [Patient 3] appears motivated and engaged. It showed the document was prepared and signed by Staff F, SUDPT on June 6, 2024 and signed by Staff A on June 6, 2024.

E. Review of the document titled “Custom Monthly Report”, dated May 31, 2024, showed an identical report to the “Monthly Compliance Report” dated May 31, 2024, however; this report showed the date of enrollment as June 28, 2024 and did not contain Patient ’s treatment activity that showed how many appointments they attended and how many they missed for that

review period. It showed the document was prepared by Staff A and signed by Staff A on June 28, 2024.

F. Review of the document titled “Monthly Compliance Report”, dated June 30, 2024, showed Patient 3's date of enrollment as January 5, 2024. It showed that Patient 3 was excused for three (3) outpatient telehealth sessions and that they missed two (2) outpatient sessions. The document showed that Patient 3 was scheduled for a random UA on June 3, 2024 which they missed; that they submitted a UA on June 10, 2024, for MAT services, that was negative; and that they submitted a UA June 21, 2024, that was positive for prescribed medications. It showed Patient 3 was marked to be “in full compliance”. It showed, “[Patient 3] continues to do great in groups and one on ones. [Patient 3] appears motivated and engaged. It showed the document was prepared by Staff A and signed by Staff A on July 10, 2024.

G. Review of the document titled “Custom Monthly Report”, dated June 30, 2024, showed an identical report to the “Monthly Compliance Report” dated June 30, 2024; however, this report showed the date of enrollment as June 28, 2024 and did not contain Patient 3’s treatment activity showing how many appointments they attended and how many they missed for that review period. It showed the document was prepared by Staff A and signed by Staff A on July 12, 2024.

H. Review of Patient 3’s patient record showed a section titled “Lab Testing” that contained results of UAs that had been sent to the lab for testing. It showed that UAs dated April 11, 2024 and April 24, 2024 indicated Patient 3 had a prescription for Pregabalin [anticonvulsant and nerve pain] and Duloxetine [anti-depressant], but that the April 11, 2024 UA did not detect Duloxetine and both the April 11, 2024 and the April 24, 2024 UA did not detect Pregabalin, and therefore the results were “unexpected, not detected”. Review of the record showed that it did not contain any UA testing results between April 24, 2024 and June 3, 2024.

I. Review of Patient 3’s patient record showed a section titled “Prescription” that showed printouts of DOH’s Prescription Monitoring Program (PMP) database, dated January 30, 2024; May 8, 2024; June 5, 2024; June 10, 2024; and June 27, 2024. Review of the report dated June 27, 2024 showed that the search range for Patient 3’s prescription medications was June 27, 2023 through June 7, 2024. It showed that between July 22, 2023 and December 6, 2023 Patient 3 had active prescriptions for Pregabalin and Alprazolam [a benzodiazepine]. It showed that between March 1, 2024 and June 7, 2024 Patient 3 had active prescriptions for Zolpidem Tartrate [sleeping medication known as Ambien]; Oxycodone; and Modafinil [non-amphetamine

stimulant]. Patient 3's file did not contain any additional prescriptions. Prescription information was inconsistent affecting treatment outcomes. Prescriptions and prescription dates captured in the PMP do not correspond with active prescriptions for the medications that were being reported by the agency to the laboratory as being prescribed.

1.25 During a phone interview with a former employee, Staff BB, SUDPT, on July 25, 2024, they stated that the agency engaged in unethical and unprofessional practice. Staff BB reported that they completed an assessment with a patient [later identified as Patient 5] and that during the assessment the patient disclosed that they had open and pending court cases, including charges for rape of a minor. Staff BB stated they captured this information in the assessment; that the next day Patient 5 was transferred to Staff GG, former staff and SUDPT; and that Staff GG requested Staff BB to change the assessment to exclude information about the rape of a minor charge. Staff BB stated that they refused to change the assessment; that Staff GG removed Staff BB's assessment in the electronic health records system and completed a second assessment; and that the patient was billed for a second assessment.

A. Review of undated screenshots provided to Investigator 1 by Staff BB on August 8, 2024, showed a message exchange between Staff BB and Staff GG. It showed that Staff GG wrote, "… in regard to [Patient 5's] intake I am happy to button up [their] plan for future care, however personal details associated with [their] alleged accusation will be removed from [their] assessment before I will touch [Patient 5's] case". Screenshots provided showed that the exchange between Staff BB and Staff GG was captured, and forwarded to Staff A, CEO and SUDP, and Staff S, former Clinical Director and SUDP, in a separate message. It showed Staff S responding, "Thank you, I will handle it, …". It showed Staff BB responding to Staff S, stating that they had staffed the issue with their lead, Staff D, SUDPT, and that they felt frustrated because what Staff GG was asking them to do was unethical. It showed that Staff A was copied on these exchanges.

B. Review of the clinical record for Patient 5 showed a document titled "Adult Psychosocial Assessment", dated February 13, 2024 at 11:33 AM. It showed the assessment was completed in-person and that it contained the patient's signature dated February 13, 2024. It showed that Patient 5 endorsed, in Dimension 3, and in Dimension 4, that they had domestic violence (DV) and rape of a minor charges; that they had two (2) previous DUI's; and that their substance use negatively affected their mental health and their behaviors. The assessment showed comprehensive documentation of answers, including direct quotes, in response to assessment questions. It showed that

Patient 5 was diagnosed with F10.20 and that nine (9) DSM5 diagnostic criteria were met. It showed the level of care recommendation at Level 3.5. It showed the assessment was signed by Staff BB on February 13, 2024 and by Staff S, former Clinical Director and SUDP on February 14, 2024.

C. Review of the clinical record for Patient 5 showed a document titled "Adult Psychosocial Assessment", dated February 13, 2024 at 10:20 AM. It showed the assessment was completed via telehealth and that it contained a patient signature, "verbal", dated February 14, 2024. It showed the primary diagnosis as F10.20, alcohol dependence, severe, in the summary header of the assessment. It showed that the assessment did not contain information in Dimension 3 or in Dimension 4 related to how the patient's substance use affected their mental health or behaviors, or regarding any open or pending court cases. It showed in Dimension 3 that, "[Patient] was referred to evaluate with [Psychiatric Evaluation and Treatment Center] to serve both detox from alcohol needs as well as mental health." The assessment did not contain comprehensive documentation of answers, or direct quotes, in response to assessment questions. It showed inconsistencies with the assessment completed by Staff BB on the previous day. This assessment showed that it did not contain sufficient information to determine the ASAM level of care. It showed that Patient 5 was diagnosed with F10.20, alcohol dependence, severe, and that nine (9) DSM-5 diagnostic criteria were met. It showed that the overall level of care recommendation at Level 2.1. The assessment showed that all DSM-5 diagnostic criteria from the previous assessment were maintained and that it did not contain a clinical justification for stepping Patient 5 down to ASAM level 2.1. It showed the assessment was signed by Staff GG on February 14, 2024 and by Staff S, former Clinical Director and SUDP, on February 15, 2024.

D. Review of the clinical record for Patient 5 showed a document titled "Treatment Plan", dated June 20, 2024. It showed the diagnosis as F10.20, alcohol dependence, severe; the type and frequency of treatment services as intensive outpatient with a duration of nine (9) months; the LOC as 2.1; and the legal requirements as "DUI". It showed that during a review completed on July 19, 2024, Patient 5 denied knowledge of problem statements and goals for Dimension 2; that Patient 5 denied knowledge of and disagreed with the problem statement in Dimension 3; and that they denied knowledge of the goal and intervention listed in Dimension 4. The review of Dimension 5 showed that Patient 5 had missed a random UA in June and that as of July 19, 2024 they were going to participate in mouth-swab testing, groups. and UAs. Patient 5's clinical record did not contain additional treatment plans or referrals.

E. Review of the clinical record for Patient 5 showed a section titled “Lab Test Results” and contained eight (8) UA lab testing results dated February 17, 2024 through July 3, 2024. The UA results dated February 17, 2024 showed that Patient 5 tested positive for amphetamines, methamphetamines and cTHC (marijuana metabolite). Five (5) UA results dated March 4, 2024 through May 15, 2024 showed that Patient 5 tested positive for either cTHC or THC. One (1) UA result dated July 3, 2024 tested positive for THC and alcohol metabolites. A UA result dated June 24, 2024 showed that Patient 5 tested negative for all substances.

F. Review of the clinical record for Patient 5 showed a section titled “Monthly Reports”, that contained six (6) monthly progress reports dated February 29, 2024 through July 31, 2024. A monthly progress report dated February 29, 2024 showed that Patient 5 tested positive for cannabis and that “[their] levels have not lowered since the initial test was provided.” This report did not contain information about Patient 5’s UA testing positive for amphetamines and methamphetamines on February 17, 2024 and also did not list the supervising agency or who this progress report was being provided to. Monthly progress reports dated March 30, 2024 through July 31, 2024 showed that the supervising organization was listed as Individual #2, Public Defender.

G. Review of the clinical record for Patient 5 showed that it did not contain active prescriptions for cannabis.

2. Conclusions of Law

2.1 Based on the Alleged Facts, Rainier Recovery has placed the health and safety of the public at risk for serious injury, harm, impairment, or death by violating RCW 71.24, WAC 246-341, WAC 246-811, WAC 246-341-0335(1)(a) and (e), WAC 246-341-0410(4)(b-e), WAC 246-341-0510(1), WAC 246-341-0515(1-2), WAC 246-341-0640(1)(c), (d), and (g) and (2)(b), (c), (d), and (h), WAC 246-341-0737(4)(a), (c), and (d), WAC 246-811-035, and WAC 246-811-048(2).

WAC 246-341-0335 Agency licensure and certification—Denials, suspensions, revocations, and penalties.

(1) The department will deny issuing or renewing an agency's license or certification(s), place an agency on probation, or suspend, or revoke an agency's license or certification, for any of the following reasons:

(a) The agency fails to meet applicable requirements in this chapter, chapters 71.24, 71.05, 71.34, and 71.12 RCW, or RCW 41.05.750.

...

(e) The department determines there is imminent risk to health and safety.

... .

WAC 246-341-0410 Agency administration—Administrator key responsibilities.

...

(4) The administrator or their designee must ensure:

...

(b) There is sufficient qualified personnel to provide adequate treatment services and facility security;

(c) All persons providing clinical services are appropriately credentialed for the clinical services they provide;

(d) Clinical supervision of all clinical services including clinical services provided by trainees, students, and volunteers;

(e) There is an up-to-date personnel file for each employee, trainee, student, volunteer, and for each contracted staff person who provides or supervises an individual's care;

... .

WAC 246-341-0510 Personnel—Agency record requirements.

A behavioral health agency must maintain a personnel record for each person employed by the agency.

(1) The personnel record must contain all of the following:

(a) A signed position description.

(b) A signed and dated commitment to maintain patient (individual) confidentiality in accordance with state and federal confidentiality requirements.

(c) A record of an orientation to the agency within 90 days of hire that includes all of the following:

(i) An overview of the agency's policies and procedures.

(ii) Staff ethical standards and conduct, including reporting of unprofessional conduct to appropriate authorities.

(iii) The process for resolving client concerns.

(iv) Cultural competency.

(v) Violence prevention training on the safety and violence prevention topics described in RCW 49.19.030.

(vi) If providing substance use disorder services, prevention and control of communicable disease, bloodborne pathogens, and tuberculosis.

(d) A record of annual training that includes:

(i) Cultural competency; and

(ii) If providing substance use disorder services, prevention and control of communicable disease, bloodborne pathogens, and tuberculosis.

(e) A record of violence prevention training on the safety and violence prevention topics described in RCW 49.19.030; annually for employees working directly with clients receiving mental health services per RCW

71.05.720 or according to the agency's workplace violence plan required per RCW 49.19.020.
(f) A copy of the staff member's valid current credential issued by the department if they provide clinical services.
... .

WAC 246-341-0515 Personnel—Agency staff requirements.

Each behavioral health agency must ensure that all of the following staff requirements are met:
(1) All staff providing clinical services are appropriately credentialed for the services they provide, which may include a co-occurring disorder specialist enhancement.
(2) All staff providing clinical services receive clinical supervision.
... .

WAC 246-341-0640 Individual service record content.

A behavioral health agency is responsible for the components and documentation in an individual's individual service record content unless specified otherwise in certification or individual service requirements.
(1) The individual service record must include:
...
(c) An assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes:
(i) Presenting issue(s);
(ii) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm and, if the assessment indicates there is such a risk, a referral for provision of emergency/crisis services;
(iii) Treatment recommendations or recommendations for additional program-specific assessment;
(iv) A diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable Diagnostic and Statistical Manual of Mental Disorders (DSM-5), or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5);
(v) A placement decision, using ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services.
(d) Individual service plan that:

(i) Is completed or approved by a person appropriately credentialed or qualified to provide mental health, substance use, co-occurring, or problem gambling disorder services;
(ii) Addresses issues identified in the assessment and by the individual or, if applicable, the individual's parent(s) or legal representative;
(iii) Contains measurable goals or objectives and interventions;
(iv) Must be mutually agreed upon and updated to address changes in identified needs and achievement of goals or at the request of the individual or, if applicable, the individual's parent or legal representative;
(v) Must be in a terminology that is understandable to the individuals and the individual's family or legal representative, if applicable.
...
(g) If treatment is for a substance use disorder, documentation that ASAM criteria was used for admission, continued services, referral, and discharge planning and decisions.
...
(2) When the following situations apply, the individual service record must include:
...
(b) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred.
(c) If treatment is court-ordered, a copy of the order.
(d) Medication records.
...
(h) If a report is required by a third-party, a copy of any report required by third-party entities such as the courts, department of corrections, department of licensing, and the department of health, and the date the report was submitted.
... .

WAC 246-341-0737 Behavioral health outpatient intervention, assessment and treatment services – Certification standards.

...
(4) Agencies choosing to provide outpatient involuntary or court-ordered services must report noncompliance, in all levels of care, for an individual ordered into substance use disorder treatment by a court of law or other appropriate jurisdictions in accordance with RCW 71.05.445 and chapter 182-538D WAC for individuals receiving court-ordered services under chapter 71.05 RCW, RCW 10.05.090 for individuals under deferred prosecution, or RCW 46.61.5056 for individuals receiving court-ordered treatment for driving under the influence (DUI). Additionally, agencies

providing services to individuals under a court-order for deferred prosecution under RCW 10.05.090 or treatment under RCW 46.61.5056 must:
(a) Report and recommend action for emergency noncompliance to the court or other appropriate jurisdiction(s) within three working days from obtaining information on:
(i) An individual's failure to maintain abstinence from alcohol and other nonprescribed drugs as verified by individual's self-report, identified third-party report confirmed by the agency, or blood alcohol content or other laboratory test;
(ii) An individual's report of subsequent alcohol or drug related arrests; or
(iii) An individual's leaving the program against program advice or an individual discharged for rule violation;
...
(c) Transmit information on noncompliance or other significant changes as soon as possible, but no longer than 10 working days from the date of the noncompliance, when the court does not wish to receive monthly reports;
(d) Report compliance status of persons convicted under chapter 46.61 RCW to the department of licensing.

WAC 246-811-035 Certification of a substance use disorder professional trainee.

(1) To apply for a substance use disorder professional trainee certificate an applicant shall:
(a) Submit an application on forms provided by the department, including any written documentation needed to provide proof of meeting the eligibility requirements as indicated on the application;
(b) Declare that they are enrolled in an approved school or approved and registered apprenticeship program and gaining the experience required to receive a substance use disorder professional credential;
(c) Pay applicable fees in WAC 246-811-990.
(2) To apply for annual renewal, a substance use disorder professional trainee must submit to the department applicable fees in WAC 246-811-990 and a signed declaration with their annual renewal that states they:
(a) Are enrolled in an approved educational program or approved and registered apprenticeship program; or
(b) Have completed the educational requirements in WAC 246-811-030 and are obtaining the experience requirements for a substance use disorder professional credential in WAC 246-811-046 or 246-811-050.
(3) A substance use disorder professional trainee certificate can only be renewed four times, except as provided in RCW 18.205.095.

WAC 246-811-048 Supervision requirements.

...

(2) A substance use disorder professional or an individual credentialed according to WAC 246-811-076 may provide substance use disorder assessment, counseling, and case management to patients consistent with his or her education, training, and experience as documented by the approved supervisor.
(a) The first fifty hours of any face-to-face patient contact must be under direct supervision and within sight and hearing of an approved supervisor or a substance use disorder professional designated by the approved supervisor.
(b) An approved supervisor or the approved supervisor's designated certified substance use disorder professional must provide direct supervision when a supervisee is providing clinical services to patients until the approved supervisor documents in the employee file that the supervisee has obtained the necessary education, training, and experience.
... .

2.2 The above violations provide grounds for a finding of immediate jeopardy under RCW 71.24.025(8).

3. Legal Authority

The Department is authorized to make the suspension of a behavioral health agency license effective immediately upon receipt of the notice by the licensee, if the Department determines a licensee's noncompliance results in immediate jeopardy. RCW 71.24.025 and RCW 71.24.038.

4. Argument

The deficiencies substantiated by the investigations at Rainier Recovery's three (3) licensed BHA facilities show that the on-going violations are pervasive throughout all three (3) licensed locations and represent a systematic failure that has affected and will continue to affect a large portion of all patients and staff. Additionally, the noncompliance at all three (3) licensed locations operated by Rainier Recovery LLC has resulted in immediate jeopardy to patient safety which necessitates immediate action as the noncompliance has caused, and is likely to continue causing serious injury, harm, and death to a patient receiving care at one of these locations.

Immediate Jeopardy

The above violations amount to noncompliance resulting in immediate jeopardy and warranting a suspension of Rainier Recovery's Behavioral Health Agency license effective immediately pending any adjudicative proceeding.

As substantiated above, leadership at Rainier Recovery has engaged in an extensive pattern of corrupt practices that violate applicable standards and creates a foreseeable risk of serious harm to patients.

Patients, and especially those who have been ordered by a criminal court to avail themselves of substance use disorder (SUD) assessments and treatment, are particularly vulnerable people. Further SUD is a complex condition that, if not addressed correctly, can lead to poor patient outcomes to include overdose and death.

Rainier Recovery has engaged in the practice of employing people as Substance Use Disorder Professional Trainees (SUDPTs) who lack a combination of the education, training and supervision as required by law. Rainier Recovery leadership has also directed these employees on several occasions to not timely and accurately document the clinical status of their patients. This has resulted in an extensive pattern of substandard SUD services to include false and inaccurate assessments, treatment plans and monitoring such that patients are not receiving the appropriate oversight and care their condition requires, and a lack of knowledge of when to report information to external agencies, such as reporting allegations of child abuse and neglect. These deficient practices have created a reasonable expectation of adverse patient outcomes to include serious harm.

Rainier Recovery management's corrupt practices are motivated by financial considerations instead of the clinical needs of the patients and the needs of the criminal justice system to accurately monitor the patient's treatment status. Rainier Recovery management is reported to be altering patients' clinical records based on requests from the patient's attorney without any clinical justification to do so, thus reducing the effectiveness of the level of care and minimizing the scrutiny placed on the court-ordered clients referred to this agency for treatment and monitoring. Rainier Recovery has also failed to timely report required information to the criminal justice system, such as unexpected or positive urinalysis results.

Rainier Recovery clients who receive substandard treatment services from unqualified staff are more likely to continue to use substances risking self-harm to include possible overdose and death. Allowing the agency to continue to provide SUD services to any patients, court-ordered or otherwise, creates the reasonable expectation that more negative patient outcomes of a serious nature will result.

Need for Immediate Enforcement Action

In light of the above deficient practices, the Department must take immediate action to address the risk they pose to patients as well as the public in general.

The evidence in this matter reveals serious deficiencies in Rainier Recovery's administration. Management has directed staff to misrepresent information in client treatment records and allow staff members to provide SUD treatment services when they lack the necessary education and oversight. These deficiencies have created an agency that has and will continue to operate in a manner that puts financial considerations before patient care.

In the case of its court-ordered clients, Rainier Recovery has also been deficient in the reporting of clients' treatment and monitoring status to appropriate branches of the criminal justice system. These practices fail to ensure the criminal justice system is kept fully apprised of the client's true clinical status and their compliance with the court order in their criminal case. On more than one occasion, Rainier Recovery has intentionally failed to timely report clients' noncompliance with court ordered provisions of sobriety.

These non-disclosures present an immediate risk to not only Rainier Recovery clients but to the public at large. Defendants charged or convicted of driving under the influence who are court-ordered into treatment and monitoring due to a substance use disorder are at risk of continuing to drive impaired if not adequately monitored by the licensed agencies entrusted to do so. This breach of trust poses a present danger to all citizens sharing the road with Rainier Recovery's clients.

Rainier Recovery's efforts to thwart its obligation to provide timely and accurate noncompliance reporting to the courts was flagrant and intentional. Corrupt practices of this severity, involving such a critical aspect of agency responsibilities, raises doubts as to Rainier Recovery's overall ability to provide safe and competent care to any of its clients.

The above noncompliance continues to pose immediate jeopardy as defined in chapter 71.24 RCW and warrants a full and immediate suspension of Rainier Recovery's BHA license. In light of the scope and severity of the substantiated legally deficient and extensively corrupt practices, there is no less restrictive means to address the serious risk in the immediate than to temporarily suspend Rainier Recovery's license.

5. Request for an Adjudicative Proceeding:

Rainier Recovery has the right to contest the suspension by requesting an adjudicative proceeding, including the ability to request a show cause hearing on whether an immediate jeopardy exists.

To contest the department's decision, you or your representative must complete and file the attached "Application for Adjudicative Proceeding" or similar document, and file the

request with the Department's Adjudicative Service Unit (ASU) in a manner that shows proof of service on the ASU within twenty-eight (28) days from receipt of this decision.

The mailing address is:	The physical address is:
Department of Health	Department of Health
Adjudicative Service Office	Adjudicative Service Office
Post Office Box 47879	111 Israel Road SE
Olympia, WA 98504-7879	Tumwater, WA 98501

Email: ACOfax@doh.wa.gov (For filing under the emergency rules)

Dated: 11/26/2024.

By: John Williams (Nov 26, 2024 08:14 PST)

JOHN WILLIAMS
EXECUTIVE DIRECTOR
OFFICE OF COMMUNITY HEALTH SYSTEMS

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

HEALTH SYSTEMS QUALITY ASSURANCE

Enclosures

cc: AAG
OAS
OILS
OCHS
ACO