STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	01/17/2019

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS . STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 conducted this health and safety survey. Onsite dates: 01/08/19 - 01/11/19 and 01/15/19 - 01/17/19 Examination number: 2018-978 The survey was conducted by: Surveyor #2 Surveyor #3 Surveyor #5 Surveyor #9 Surveyor #10 Surveyor #11 The Washington Fire Protection Bureau conducted the fire life safety inspection. During the course of the survey, surveyors assessed issues related to complaints #2018-16078, 2018-17308, 2018-17557, 2018-17724, 2018-17798, 2018-18050, 2018-18052, 2018-18054, 2018-18062, 2018-18218, 2019-39, and 2019-882. In addition, a Medicare Complaint Survey (Intake #87038) was also conducted with this hospital licensing survey. .	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 04/03/19. 4. Return the ORIGINAL REPORT with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT	L 315		

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L 315	Continued From page 1 WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted for 2 of 10 records reviewed. (Patient #501, #901) (Item #1), and failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs for 2 of 3 patients with Diabetes Mellitus reviewed (Patient #501 and #503) (Item #2). Failure to provide patients with services that meet the patient's healthcare needs risks deterioration of the patient's condition and poor healthcare outcomes. Item #1 - Dietary Consultations Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutritional Service for Patients," no policy number, effective 05/17, showed that a nurse will perform a nutritional screen and initiate a dietary consult when a potential for malnutrition has been identified or the patient has a medical disorder such as diabetes.	L 315		

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L 315	Continued From page 2 2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient had a medical history of Diabetes Mellitus Type II and a blood sugar of 387 documented in the Emergency Room prior to admission to the psychiatric hospital. The patient's history showed the patient had underwent gastric bypass surgery one and a half years ago. On 01/06/19 at 12:30 AM, a provider ordered a regular diet and an ADA diet (American Diabetic Association diet). Surveyor #5 and Staff #505 found no evidence that staff obtained a clarification order for which diet was correct. Surveyor #5 and Staff #505 reviewed the patient's dietary card and found the patient was receiving a diabetic diet. Surveyor #5 and Staff #505 reviewed the dietician consult form and found the patient received a nutritional screen but did not need a dietician's consultation. 3. At the time of the observation, during an interview with Surveyor #5, the Registered Nurse (RN) (Staff #505) stated that patients with diabetes should receive a dietary consult. The nurse was unaware that the patient had a gastric bypass surgery. 4. On 01/16/19 at 2:23 PM, Surveyor #5 and Surveyor #2 interviewed a dietician (Staff #510) about the dietary consultation process. Staff #510 stated that nursing staff complete a nutritional screening upon admission. She would only become aware of a patient's diagnosis requiring a dietary consult if she received a dietary consultation request. She stated that she did not receive a dietary consultation request for this patient. She stated that nursing staff completes	L 315		

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L 315	Continued From page 3	L 315		

the dietary order card and sends it to the dietary staff. The dietician does not reconcile the cards sent from the nursing staff against the physician diet order.

5. On 01/09/19 at 11:45 AM, Surveyor #9 reviewed the medical record of Patient #901 who was admitted on 10/15/18 with a diagnosis of depression and psychosis. The record review showed that the patient had an initial medical consult on 10/16/18 that identified his concurrent diagnosis of diabetes type 2, hypertension (high blood pressure), and hyper cholesteremia (high cholesterol). The physician (Staff #901) conducting the medical consultation ordered a dietary consult. As of 01/09/19, a dietary consult had not been completed.

6. At the time of the medical record review, Surveyor #9 interviewed the Director of Transitional Care Unit (Staff #902) about the lack of a dietary consult. She acknowledged that the dietary consult was not in the record and it appeared it was not completed. She took action at this time to contact the dietician for a consult.

Item #2 Diabetes Management

Findings included:

1. Document review of the hospital's document titled, "Medical Staff Rules and Regulations," dated 04/17, state that the attending physician shall assume and accept full responsibility for the quality of the clinical care for his/her patients ....the admitting physician must give complete orders including but not limited to precautions to be followed and labs to be drawn.

Document review of the hospital's document

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L 315	Continued From page 4	L 315		

titled, "Smokey Point Behavioral Hospital Governing Board Bylaws and Constitution," dated 06/17, states that the Governing Board is ultimately accountable for the quality of patient care, treatment, and services.

2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The review showed:

-The Psychiatric Evaluation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2.

-The Initial Medical Consultation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2 and a blood sugar of 387 in the Emergency Room prior to admission to the psychiatric hospital.

-On 01/06/19 at 4:40 PM, a provider order directed nursing staff to check the patient's blood sugar level twice daily. The provider's order did not provide direction for staff response to the patient's blood sugar level.

-Review of blood sugar documentation on the medication administration record from 01/06/19 until 01/08/19 showed the patient's blood sugar level ranged from 157 mg/dl to 240 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels.

3. At the time of the observation, Surveyor #5 asked the Registered Nurse (RN) (Staff #505) at what blood sugar levels did he need to notify the provider. Staff #505 stated that he did not know

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what the blood sugar parameters were and he would need to look at the policy. A search for a policy revealed there was no policy or protocol that addressed blood sugar management or parameter to notify the provider.

Staff #505 verified there were no provider orders to direct staff when to notify the provider and no orders to treat high or low blood glucose levels.

4. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511), and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patients #503. Patient #503 was admitted for suicidal ideation with intent to harm oneself, major depression, and visual hallucinations. The review showed:

-The Psychiatric Evaluation completed on 01/04/19 showed a medical history of Diabetes Mellitus Type 2

-The Initial Medical Consultation completed on 01/04/19 showed a medical history of Diabetes Mellitus Type 2.

-On 01/04/19, a provider ordered blood sugar checks in the morning and before the patient's evening meal.

-Review of blood sugar documentation from 01/04/19 until 01/09/19 showed the patient's blood sugar level ranged from 122 mg/dl to 299 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels.

4. At the time of the observation, Surveyor #5 asked the LPN (Staff #509) at what blood sugar levels did she need to notify the provider. Staff

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L 315	Continued From page 6 #509 stated that there was an, "element of judgement." Staff #509 verified there were no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels. 5. On 01/16/19 at 4:45 PM, a Physician (Staff #513) provided Surveyor #5 with a copy of a document titled, "Data Entry for Blood Glucose Quality Control," dated 06/17. Staff #513 stated this was a form adopted to guide staff about when to call the provider for low and high blood sugars. Surveyor #5 reviewed the form and noted it was a quality control form for checking controls on the blood sugar machines. It included a column for the control chem-strip lot number, expiration date and code number. It contained a column for acceptable control ranges for low and high that were define above the column as "low range would be 29-59 mg/dl and the high range should be 222-371 mg/dl." It also contained a column to document cleaning and maintenance of the machine. Surveyor #5 found no evidence that this form was an order or protocol to direct staff when to notify a provider of low or high patient blood sugar levels. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L 315		
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 320		

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L 320	Continued From page 7 services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure review and resolution of a patient grievance went through the grievance committee for 1 of 2 grievances reviewed. Failure to review and approve resolution of grievances by a committee instead of an individual risks incomplete or inadequate evaluation of all aspects of the grievance issue. Findings included: 1. Document review of the hospital's policy and procedure titled, "Grievances and the Patient Advocate," no policy number, effective 05/17, showed that the patient advocate will investigate all complaints received from patients and others. Each patient making a complaint and others making a complaint will receive a response from the facility staff that addresses the complaint in a timely manner (within one week). A written response is to be provided within 30 days of the filed grievance. The Chief Executive Officer shall have final authority and responsibility in resolving grievances. 2. On 01/16/19 at 1:50 PM, Surveyor #3 interviewed the Director of Quality and Risk Management (Staff #308) about the grievance investigation and resolution process. Staff #307 stated grievances are investigated and reported through the performance improvement and	L 320		

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L 320	Continued From page 8 grievance committees. The grievance committee consists of the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the Program Directors, and the Chief of Clinical Services. The grievance committee meets monthly. 3. On 01/16/19 at 2:00 PM, Surveyor #3 reviewed the 2018 grievance log. The surveyor observed that two grievances had been filed in December with one remaining open. The surveyor asked Staff #308 if the one closed grievance filed in December had gone through the grievance committee process. Staff #308 stated the grievance had not gone through the grievance committee. Staff #308 reviewed, investigated, and closed the grievance himself rather than referring it to the grievance committee. .	L 320		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed. This Washington Administrative Code is not met as evidenced by: . Based on record review, the hospital failed to ensure that required policies and procedures were reviewed and updated annually as required. Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety.	L 415		

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L 415	Continued From page 9 Findings included: Record review of the following policies showed that the facility did not review them on an annual basis as required. All of the following policies had an effective date of 05/17 with no subsequent review date and no policy numbers: a. Admission, Discharge, and Continued Stay b. Assessment of Patients c. Individual Rights d. Patient Rights e. Abuse Reporting f. Fire Drills g. CPR Code Blue h. Assaultive Behaviors i. Use of Restraints j. Use of Seclusion k. Use of Restraints and Seclusion l. Physician's Orders k. Written Medication Orders l. Surveillance: Collecting, Analyzing, and Reporting m. Isolation Procedures n. Elopement: Reporting Unauthorized Leave	L 415		

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L 415	Continued From page 10 o. Death of a Patient p. Patient Smoking q. Personal Property r. Scheduling Services at another Facility s. Memorandum of Transfer t. Criminal Background Checks u. Use of Investigational Drugs v. Food Storage w. Food Preparation x. Cleaning and Sanitizing of Work Areas/Rooms	L 415		
L 440	322-040.5 ADMIN-MEDICAL DIRECTOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the governing body failed to formally appoint a medical director to oversee the medical staff. Failure to appoint a medical director to oversee medical treatment risks patients receiving	L 440		

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L 440	Continued From page 11 inadequate or substandard care. Findings included: 1. Record review of the governing board meeting minutes from 10/16/18 showed that the previous medical director resigned. Record review of the governing board meeting minutes from 10/16/18 and 10/22/18 did not show that the governing board formally appointed a new medical director. No subsequent board meetings had occurred at the time of review. 2. On 01/16/19 from 1:00 PM to 1:34 PM, Surveyors #2, #3, and #5 interviewed the governing body. During the interview, the Senior Clinical Vice President (Staff #202) stated that the governing board selected a new medical director (Staff #203), but failed to appoint him in writing. .	L 440		
L 495	322-040.8i ADMIN RULES-PERFORM EVALS WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (i) Mechanisms to monitor and evaluate quality of care and clinical performance; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of the hospital's quality program and quality documentation, the hospital failed to identify, track, and investigate patient safety events as	L 495		

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L 495	Continued From page 12 directed by its process improvement plan for 9 of 13 patient safety events identified during survey (Item #1); failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan (Item #2); failed to ensure that data regarding medication errors, assaults, and patient falls, were analyzed for patterns, trends, and common factors through the hospital's quality program (Item #3); the hospital failed to develop and implement performance improvement activities and action plans that supported hospital quality indicators related to patient safety and quality of care (Item #4); the hospital failed to ensure corrective actions for identified adverse events were implemented and monitored for effectiveness (Item #5); and failed to ensure the system implemented to monitor corrective actions for previously identified deficiencies was robust enough to maintain a continued level of acceptable compliance (Item #6). Failure to develop a coordinated process to oversee the performance of all patient care services and departments risks provision of improper or inadequate care and limits the hospital's ability to improve patient outcomes. Item #1 Patient Safety Findings included: 1. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital Governing Board Bylaws and Constitution," dated 06/17, states that the Governing Board is ultimately accountable for the quality of patient care, treatment, and services. Document review of the hospital's document	L 495		

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L 495	Continued From page 13 titled, "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, identified Governing Board responsibilities as: -Overseeing a coordinated, systematic, hospital-wide approach to improving patient care and health outcomes -Setting goals, timeline, and approval of written performance or quality assessment plan -Regularly reviewing and monitoring progress toward achieving this plan The plan identified performance improvement indicators including "incidents, adverse events, sentinel events, and critical incidents" The document stated that the PI committee is responsible for providing oversight of the hospital's systems for process improvement, including clinical outcomes, evidence based practice, resource utilization and patient safety. The committee will receive reports from Risk and Safety, and use data sources in evaluation of the need for quality improvement teams. The Manager of PI and risk is authorized to conduct any necessary investigation in cases of significant incidents or sentinel events. Any events requiring root cause analysis and process improvement are reported to the PI committee for monitoring and follow-up. 2. From 01/08/19 through 01/11/19, Surveyor #3, Surveyor #5, Surveyor #9, and Surveyor #10 reviewed 13 medical records and identified 13 patient safety incidences. Review of the hospitals incident report log showed that 9 of the 13 safety incidents were not identified, logged into the incident reporting system, or investigated. The	L 495		

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L 495	Continued From page 14 events identified included: a. Patient #505: Suicide Attempt on 10/04/18 b. Patient #506: Suicide Attempt on 11/22/18 c. Patient #507:Suicide Attempt on 12/02/18 d. Patient #508: Sexual Victimization (female adolescent patient touched inappropriately and without permission by a male peer) on 12/09/18 and 12/10/18 e. Patient #509: Medication Error on 12/13/18 f. Patient #510: Assaulted Staff, threw furniture, and required police to be called on 12/16/18 g. Patient #511: Assaulted a peer on 12/21/18 h. Patient #512: Ingested Contraband resulting in patient transfer to hospital on 12/24/18 i. Patient #513: Medication Error (six missed doses) started on 01/03/19 3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the SR Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program. Surveyor #5 compared the incident report log provided by the hospital with these incidences and noted the incidences had not been identified, logged, or investigated. Staff #513 and #514 confirmed the finding and stated that the process they have in place at this time for identifying and managing incidents is not effective. Item #2 Quality Care Assessment and Improvement Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no	L 495		

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L 495	Continued From page 15 policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to determine if there are opportunities for improvement, to identify suspected or potential problems, to prevent or resolve problems, and to monitor effectiveness of actions taken. The objective of the plan is to assure coordination and integration of all quality improvement activities by maintaining a PI Committee that all quality improvement information will be exchanged and monitored. 2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and SR Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program. The review showed: -The program did not include or evaluate performance metrics for the hospitals clinical contracted services. The quality review process for contracted patient care services was not part of the hospital's quality and performance improvement program. There was no mechanism for reporting process improvement recommendations through the hospital's Quality Committee. The program did not include or evaluate performance metrics for the hospitals Pharmacy Services. The quality review process for Pharmacy Services was not part of the hospital's quality and performance improvement program. Surveyor #5 found no evidence medication error data was aggregated, analyzed, or monitored for effectiveness of actions taken to reduce medication errors through the hospital's quality program.	L 495		

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L 495	Continued From page 16 3. At the time of the review, Staff #513 and Staff #514 confirmed the findings. 4. On 01/16/19, Surveyor #9 reviewed the Pharmacy and Therapeutics Committee (P & T) meeting minutes for September 2018, October 2018, and November 2018. Surveyor #9 found no evidence that medication errors or near misses had been aggregated, trended, or reported through the Quality Committee. Surveyor #9 observed that the 11/29/18 P & T minutes stated, "Future medication errors will need to be trended and analyzed for opportunities for improvement." 5. On 01/16/19 at 10:30 AM, during interview with Surveyor #9, the Pharmacy Director (Staff #908), stated that since he was hired on 11/29/18, and acknowledge that prior to his arrival medication errors had not been aggregated or trended and had not been reported to or monitored by the Quality Committee. Item #3 Data Collection and Analysis Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to: -determine if there are opportunities for improvement, -to identify suspected or potential problems, -to prevent or resolve problems, -to set process improvement priorities,-and to monitor effectiveness of actions taken.	L 495		

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L 495	Continued From page 17 The hospital will utilize comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided. 2. On 01/10/19 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis. The hospital did not stratify data by geographic location for comparison as directed by the hospital's Quality Plan. 3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and SR Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan. 4. At the time of the review, Staff #513 and Staff #514 confirmed the finding and stated that the plan and the format of the minutes needed to be re-evaluated. Item #4 Quality Improvement Activities Findings included: 1. Document review of the hospital's document	L 495		

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L 495	Continued From page 18 titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to: -determine if there are opportunities for improvement, -to identify suspected or potential problems, -to prevent or resolve problems, -to set process improvement priorities,-and to monitor effectiveness of actions taken. The document further states that assessment activities carried out by the program included data assessment to identify opportunities for improvement and facilitate setting of priorities and comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided. 2. On 01/10/19 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis. The document showed 31 falls, 88 assaults, 33 instances of contraband, and 26 employee injuries. The hospital did not stratify data by geographic location for comparison as directed by the hospital's Quality Plan. 3. On 01/15/19 from 3:00 PM until 5:00 PM,	L 495		

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L 495	Continued From page 19 Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and SR Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan. Because the hospital failed to aggregate and analyze its quality indicator data, it was unable to identify problems or potential problems, set process improvement priorities, and develop corresponding process improvement action plans and monitoring plans. 4. At the time of the review, Staff #513 and Staff #514 confirmed the finding. Staff #514 stated that the hospital's PI plan would need to be re-evaluated to include the required elements. Item #5 Adverse Event Action Plan Monitoring Findings included: 1. Document review of the hospitals policy and procedure titled, "Root Cause Analysis," no policy number, effective date 05/17, showed that the Root Cause Analysis (RCA) must identify who is responsible for monitoring whether the change has been implemented, at what frequency the monitoring will occur, and how the effectiveness of the change will be evaluated, including who will be responsible and what indicators will be used. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital 2019	L 495		

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L 495	Continued From page 20 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that sentinel events and significant incidences requiring root cause analysis and performance improvement activities are reported to the Process Improvement Committee for monitoring and follow-up. 2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the SR Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program including the hospital's adverse event log for year 2018. The log showed two events reported for 2018. Surveyor #5 reviewed 2 RCA's and noted that the hospital initiated corrective action plans for 1 of 2 of the reported adverse events. Surveyor #5 found no evidence the hospital monitored or reevaluated the corrective action plans to determine effectiveness of the interventions or measurable progress toward the established goals. 4. At the time of the review, during interview with Surveyor #5, Staff #513 and #514 confirmed the finding. Item #6 - Performance Improvement Action Plans Findings included: During the hospital's last state licensing survey completed on 03/15/18, the hospital received deficiency citations for L0315, L0495, L0505, L1065, L1150, and L1365 L. During the current survey, the hospital received a second deficiency citation for similar observations. THIS IS A REPEAT CITATION PREVIOUSLY	L 495		

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L 495	Continued From page 21 CITED ON 03/15/18. .	L 495		
L 505	322-050.1A PROVIDE PATIENT SERVICES WAC 246-322-050 Staff. The licensee shall: (1) Employ sufficient, qualified staff to: (a) Provide adequate patient services; This Washington Administrative Code is not met as evidenced by: . Based on document review and interviews, the hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment. Findings included: 1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patients and family members twenty-four hours a day. Core staffing is projected based on the following critical factors: - Patient characteristics - The number of patients receiving care, including admissions, discharges and transfers - Intensity of patient care being provided	L 505		

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L 505	Continued From page 22 -The variability of patient care across the unit -The scope of services provided, accounting for architecture and geography of the unit - Staff characteristics, including staff consistency, tenure, preparation and experience - The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise. 2. A review of the daily nurse-staffing sheet for a fourteen-day period (12/23/18 - 01/05/19) showed the following: a. The adolescent inpatient unit, which cares for children ages 12 to 17, did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 4-hour period. b. The adult intensive care unit, which cares for adults with acute and significant behavioral disturbances did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. c. The open adult unit that cares for adults with first time symptomology for behavioral health illness did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. d. The military unit which cares for adults with service connected behavioral health illness did not have a registered nurse assigned to the night shift for 1 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 2.5-hour period. 3. On 01/08/19 at 9:10 AM, Surveyor #3 inspected the adolescent inpatient unit. At the	L 505		

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L 505	Continued From page 23	L 505		

time of arrival, the surveyor observed there were three patients on the unit with no licensed nursing personnel present. Two mental health technicians (MHT) (Staff #301 and #302) were the only staff members present. Staff #301 stated the registered nurse (Staff #303) and another MHT had gone to the cafeteria for breakfast with the patients a few minutes ago.

A subsequent interview with the registered nurse upon return to the unit revealed that she usually does not leave the unit for meal times. She stated it is permissible to leave the unit as long as the unit is attended by another nursing staff member.

4. On 01/08/19 at 1:35 PM, Surveyor #5 observed Patient #501 approach the nurse's station and tell the Mental Health Technicians (MHT's) (Staff #501 and #502) at the nurses station that she was feeling shaky and weak and wanted her blood sugar tested. Surveyor #5 observed the patient ask to have her blood sugar tested two more times and then a Program Therapist (Staff #504) responded to the patient and asked for the nurse. The MHT's stated that the charge nurse (Staff #505) was at lunch and the other nurse (Staff #506) had left the unit. At that time, the Program Therapist left the unit to go get a nurse.

At 1:42 PM, a nurse (Staff #506), returned to the unit and took the patient's blood sugar. At the same time, Surveyor #5 interviewed Staff #501 and #502 who verified that there is not always a nurse on the unit at all times.

5. On 01/10/19 at 7:00 PM, Surveyor #3 interviewed a registered nurse (Staff #304) about adequacy of nurse staffing for the clinical units. The surveyor asked if there ever was a time when there was no registered nurse on the unit. Staff

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L 505	Continued From page 24	L 505		

#304 stated it has happened several times. A licensed practical nurse is in charge of the unit when no registered nurse is available. Staff #304 recalled at least one incident in which there was only one registered nurse providing care and supervision for two clinical units but could not recall the date.

6. On 01/10/19 at 7:30 PM, Surveyor #3 interviewed a mental health technician (Staff #305) about staffing. Staff #305 stated that he has been left alone on the unit at times when the assigned registered nurse was providing care and nursing coverage on another unit. He indicated that the assigned registered nurse would leave the unit to pass medications on another unit and then return to pass medications on their assigned unit.

7. On 01/11/19 at 10:00 AM, Surveyor #3 reviewed the medical record of Patient #301 who was admitted to the adolescent unit on 12/29/18 for treatment of a mood adjustment disorder. The review of the medical record showed the following:

-On 01/06/19 at 11:30 AM, a nurse wrote a nursing order for sexually acting out precautions and established a five-foot boundary rule from other patients after attempting sexual behavior in the patient's bathroom.

-On 01/09/19 at 9:45 PM, a nursing progress note showed the patient required frequent reminders about his five-foot rule with female peers.

-On 01/10/19 at 6:30 PM, a note written by a MHT (Staff # 301) showed that Patient #301 had sexual contact with Patient #302 on 01/09/19. Patient #301 informed Staff #301 that the

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L 505	Continued From page 25 consensual sexual contact occurred in the female patient's room while the MHT was passing out snacks to other patients. A review of the nurse staffing for the adolescent unit on 01/09/19 showed that the hospital had only the minimum required staffing (1 RN and 1 MHT) at the time of incident. 7. On 01/16/19 at 9:25 AM, Surveyor #3 interviewed the Chief Nursing Officer (CNO) (Staff #306) about nurse staffing for the hospital. The CNO stated that the hospital uses a nurse-staffing grid that establishes minimum staffing levels for each of the clinical units. She stated she checks the nurse-staffing schedule several times a day to ensure the units are appropriately staffed. Shortfalls in staffing are covered by calling in staff for voluntary overtime or offering shift bonuses for extra hours worked. When asked what happens if this is not effective in resolving the shortage, the CNO stated, "We do what we can". She acknowledged there are occasions when the only licensed nurse staff member on a clinical unit is a licensed practical nurse (LPN). During those occasions, a registered nurse will supervise or cover more than one nursing unit at a time. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L 505		
L 545	322-050.6A ORIENTATION-ORG WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (a)	L 545		

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L 545	Continued From page 26 Organization of the hospital; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that agency staff were oriented to the organization of the hospital for 2 of 3 staff members reviewed (Staff #205, #207). Failure to orient staff to the organization of the hospital places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for two contracted registered nurses (Staff #205 and #207) showed that the staff members did not have any documentation of orientation regarding the organization of the hospital. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205 and #207. Staff #210 confirmed that documentation of orientation on the organization of the hospital was not in the employee personnel files.	L 545		
L 550	322-050.6B ORIENTATION-PHYSICAL LAYOUT WAC 246-322-050 Staff. The licensee shall: (6) Provide and document	L 550		

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L 550	Continued From page 27 orientation and appropriate training for all staff, including: (b) Physical layout of hospital, including buildings, departments, exits, and services; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that agency staff were oriented to the physical layout of the hospital for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff to the physical layout of the hospital places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for one contracted registered nurse (Staff #205) showed that the staff member did not have any documentation of orientation regarding the hospital's physical layout. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that documented orientation on the hospital's physical layout was not in the employee personnel files.	L 550		

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L 555	Continued From page 28	L 555		
L 555	322-050.6C TRAINING-DISASTER PLANS WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (c) Fire and disaster plans, including monthly drills; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on the fire and disaster plan of the hospital for 2 of 3 staff members reviewed (Staff #205 and #207). Failure to orient contracted staff on the fire and disaster plan of the hospital places patients and staff at risk during emergencies. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on emergency procedures and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for two contracted registered nurses (Staff #205 and #207) showed that the staff members did not have any documentation of orientation regarding fire and disaster plans. 2. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205 and #207. Staff #210 confirmed that documentation of training	L 555		

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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L 555	Continued From page 29 regarding fire and disaster plans was not in the employee personnel files. .	L 555		
L 560	322-050.6D TRAINING-INFECT CONTROL WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (d) Infection control; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on infection control for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff on infection control places patients and staff at risk for infection. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on infection control and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of orientation regarding infection control. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff	L 560		

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L 560	Continued From page 30 #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file.	L 560		
L 565	322-050.6E ORIENTATION-DUTIES WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (e) Specific duties and responsibilities; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on specific duties and responsibilities for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff on specific duties and responsibilities places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on specific clinical duties for their assigned roles and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of training regarding specific duties and responsibilities.	L 565		

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L 565	Continued From page 31 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file.	L 565		
L 570	322-050.6F ORIENTATION-P&P WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (f) Policies, procedures, and equipment necessary to perform duties; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented to policies, procedures, and equipment necessary to perform duties for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff to policies, procedures, and equipment necessary to perform duties places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on all policies and procedures relating to hospital services and populations served and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and	L 570		

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L 570	Continued From page 32 training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of training on policies, procedures, and equipment necessary to perform duties. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file.	L 570		
L 575	322-050.6G ORIENTATION-PATIENT RIGHTS WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (g) Patient rights according to chapters 71.05 RCW and 71.34 RCW and patient abuse; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on patient rights and abuse for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff on patient rights and abuse places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on patient rights and human resources is to maintain documentation of all training completed by staff.	L 575		

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L 575	Continued From page 33 2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of training on patient rights and abuse. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file. .	L 575		
L 585	322-050.6i ORIENTATION-APPROP TRAINING WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (i) Appropriate training for expected duties This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff received appropriate training for expected duties for 1 of 3 staff members reviewed (Staff #205). Failure to orient contracted staff on specific duties and responsibilities places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff	L 585		

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L 585	Continued From page 34 are to receive training on how to perform expected duties and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of appropriate training for expected duties. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file. .	L 585		
L 590	322-050.7A INSERVICE ED-UPDATE (7) Make available an ongoing, documented, in-service education program, including but not limited to: (a) For each staff person, training to maintain and update competencies needed to perform assigned duties and responsibilities; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were provided documented in-service training to maintain and update competencies for 1 of 3 staff members reviewed (Staff #205). Failure to provide ongoing training to maintain and update competencies risks staff providing	L 590		

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L 590	Continued From page 35 substandard care to patients. Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive continued trainings to maintain competencies and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for a registered nurse (Staff #205), hired 10/23/17, showed that the staff member did not have any documentation of in-service training to maintain or update required competencies. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file. .	L 590		
L 595	322-050.7B INSERVICE ED-STAFF (7) Make available an ongoing, documented, in-service education program, including but not limited to: (b) For patient care staff, in addition to (a) of this subsection, the following training: (i) Methods of patient care; (ii) Using the least restrictive alternatives; (iii) Managing assaultive and self-destructive behavior; (iv) Patient rights pursuant to chapters 71.05 and 71.34 RCW; (v) Special needs	L 595		

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L 595	Continued From page 36 of the patient population, such as children, minorities, elderly, and individuals with disabilities; (vi) Cardiopulmonary resuscitation; and (vii) First-aid training; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that contracted staff were provided documented in-service training on least restrictive alternatives, including restraints and seclusion, for 1 of 3 staff members reviewed (Staff #205) (Item #1), and failed to ensure that patient care staff maintained current CPR training for 1 of 9 staff reviewed (Staff #209) (Item #2). Failure to provide training on least restrictive alternatives, restraints, and seclusion risks violating patient rights and unsafe care of patients. Item #1 - Least-Restrictive Alternatives Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial and ongoing training on restraints and seclusion and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for one registered nurse (Staff #205), hired 10/23/17, showed that the staff member did not have any documentation of in-service training for least restrictive alternatives, restraint, or seclusion.	L 595		

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L 595	Continued From page 37 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training files for Staff #205. Staff #210 confirmed that the training files for least restrictive alternatives, including restraints and seclusion, were not in the employee personnel file. Item #2 - CPR Training Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that patient care staff are required to maintain current CPR certification. 2. Record review of the personnel file for a registered nurse (Staff #209) showed no documentation of current CPR certification. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding CPR certification for Staff #209. Staff #210 confirmed the missing CPR certification and had an updated CPR training (completed 01/16/19) placed in the personnel file. .	L 595		
L 670	322-050.12G RECORDS-PERFORM EVALS WAC 246-322-050 Staff. The licensee shall: (12) Maintain a record on the hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to: (g) Annual performance	L 670		

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L 670	Continued From page 38 evaluations. This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that agency staff performance evaluations were conducted and retained for 1 of 3 files reviewed (Staff #205) (Item #1), and failed to ensure that required 90-day performance evaluations were conducted and retained for 2 of 6 staff members reviewed (Staff #208 and #209) (Item #2). Failure to conduct performance evaluations limits the hospital's ability to ensure that staff members are satisfactorily performing required job duties. Item #1 - Agency Staff Evaluations Findings included: 1. Record review of the hospital policy titled "Evaluations," reviewed 04/18, showed that staff receive an evaluation 90 days post-hire and annually. The policy does not mention evaluations of contracted or agency staff. 2. Record review of the personnel file for a contracted registered nurse (Staff #205) with a start date of 10/23/17, did not show evidence that the hospital conducted a performance evaluation of the staff member one year after initial employment. 3. On 01/16/19 at 9:45 AM, Surveyor #2 interviewed the Human Resources Director (Staff #211) and the Vice President of Human Resources (Staff #212) regarding employee evaluations. The Human Resources Director stated that the hospital should evaluate agency	L 670		

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L 670	Continued From page 39 staff at the end of their contract under the same process as hospital employees and the performance improvement department should be performing an overall evaluation of all contracted staff. Staff #211 confirmed the finding of the missing employee evaluation. Item #2 - 90 Day Evaluations Findings included: 1. Record review of the hospital policy titled "Evaluations," reviewed 04/18, showed that staff receive an evaluation 90 days post-hire. 2. Record review of the personnel files for a program therapist (Staff #208) and a registered nurse (Staff #209), hired 09/17/18 and 09/10/18, respectively, did not show evidence that the hospital conducted 90-day performance evaluations of the staff members. 3. On 01/16/19 at 9:45 AM, Surveyor #2 interviewed the Human Resources Director (Staff #211) and the Vice President of Human Resources (Staff #212) regarding employee evaluations. The Human Resources Director confirmed the finding of missing employee evaluations.	L 670		
L 720	322-100.1G INFECT CONTROL-PRECAUTION WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (g) Identifying specific precautions to prevent transmission of infections;	L 720		

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L 720	Continued From page 40 This Washington Administrative Code is not met as evidenced by: . Based on interview, review of hospital policies and procedures, the hospital failed to ensure that staff members put specific precautions in place for patients diagnosed with infectious disease to prevent transmission of infections (Item #1, #2). Failure to ensure that staff members implement appropriate isolation procedures for patients with infections puts patients and staff members at risk of infection from communicable diseases. Item #1- Herpes Zoster Reference: Centers for Disease Control and Prevention, "Preventing Varicella-Zoster Virus (VZV) Transmission from Zoster in Healthcare Settings," reviewed 10/17/17, states that if a patient is immunocompetent with localized herpes zoster, then standard precautions should be followed and lesions should be completely covered. If the patient is immunocompetent with disseminated herpes zoster, then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted. Findings included: 1. Document review of the hospital's policy and procedure titled, "Infection Control Policies Subject: Isolation procedures," no policy number, date issued 05/17, states that standard precautions plus contact precautions should be used for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or items in the patient's environment.	L 720		

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L 720	Continued From page 41 2. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800mg 5 times daily for 7 days. Surveyor #5 found no evidence the lesions were covered or the patient was placed on contact precautions. 3. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #504. The ICN noted that staff did not report this condition to her. She agreed that the patient should have been placed in contact isolation. Item #2- Hepatitis C Reference: Centers for Disease Control and Prevention, Division of STD Prevention, National Center for HIV/AIDS,STD, and TB Prevention (last reviewed 06/06/15) stated that Hepatitis C can be transmitted through exposures in health care settings as a consequence of inadequate infection control practices. Findings included: 1. Document review of the hospital's policy and procedure titled, "Isolation Procedures," issued 05/17 showed that standard precautions will apply to blood; all bodily fluids and secretions, except sweat; non-intact skin; and mucous membranes.	L 720		

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L 720	Continued From page 42 The document showed that standard precautions are combined with disease-specific precautions when a disease is identified. Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease risk of infectious disease included addressing infectious diseases on the medical care plan. 2. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902, admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. The record review showed that a physician (Staff #903) conducted an initial medical consultation on 01/06/19 with a medical diagnosis of Hepatitis C added to the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C. 3. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases should be added to the treatment plan. 4. On 01/08/19 at 3:00 PM, during record review, Surveyor #5 reviewed the medical record of Patient #503, admitted on 12/15/18 for suicide attempt, schizoaffective disorder, and methamphetamine abuse. On 12/31/18, the	L 720		

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L 720	Continued From page 43 patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. On 12/31/18, the record showed that a medical provider (Staff #909) wrote an order for the patient to be in "Enteric Precautions" for Hepatitis C. The patient's Kardex dated 12/27/18 showed that "Enteric Precautions" had been noted, but was crossed out and replaced with "Standard Precautions." Further review of the patient's record of every 15 minute rounding for 01/02/19, 01/03/19, 01/04/19, 01/05/19, and 01/06/19, showed the patient is noted to be in "Contact Precautions". 5. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #905. The ICN stated that staff did not appear to have an understanding of what type of precautions measures should be in place for this patient who should have been in "Standard Precautions". .	L 720		
L 765	322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control. The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing staff and administrative staff, to: (d) Meet at regularly scheduled intervals, at least quarterly; This Washington Administrative Code is not met as evidenced by: .	L 765		

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L 765	Continued From page 44 Based on interview and review of hospital documents, the hospital failed to maintain an infection control committee that meets on scheduled intervals, at least quarterly as required. Failure to hold regular meetings prevents the dissemination of information and opportunity to analyze and share identified infection control issues with hospital staff to prevention of infections. Findings included: 1. Document review of the hospital's "Infection Control Committee Meeting Minutes," showed that meetings were held on 03/29/18, 06/26/28, and 08/23/18. There were no meeting minutes for the 4th quarter of 2018. 2. On 01/16/19 at 2:30 PM, Surveyor #9 interviewed the current Infection Control Nurse (ICN) (Staff #904) about the 4th quarter infection control committee meeting, she stated that the meeting had not been held due to key staff members being on extended leave. .	L 765		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policy and procedures, the hospital staff failed to implement its policies and procedures	L 780		

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L 780	Continued From page 45 when contraband was discovered in a patient's room for 1 or 1 records reviewed (Patient #903). Failure to report, investigate, and prevent contraband and other hazardous items from entering the hospital risks patient, visitor, and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number, revised date 06/18, showed that hospital staff members would search patient rooms for contraband at least twice daily. Contraband included prohibited items such as illegal drugs and paraphernalia. The policy showed that when staff discover contraband, hospital staff would confiscate the items; immediately notify the patient, the patient's healthcare provider, and the Chief Nursing Officer; and complete an incident report. 2. On 01/10/19 at 2:30 PM, Surveyor #9 interviewed a Registered Nurse (RN) (Staff #905) regarding an allegation that Patient #903 had brought contraband into the hospital. He stated that on 12/24/18 he received a note from a patient stating that there were "drugs on the unit." The nurse conducted a room search and found some small blue rubber pieces with a white residue. The nurse contacted the Chief Nursing Officer (CNO) (Staff #906) at the time of the discovery. Staff #905 also shared this information with the healthcare providers in their treatment meeting that day. As a result, the involved patient's provider wrote an order for the patient to be on unit restriction and placed on 5-minute observational monitoring.	L 780		

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L 780	Continued From page 46 3. Staff #905 stated that around 10 AM on 12/24/18, he observed Patient #903 to be pale, sweating, and complaining of right lower quadrant abdominal pain. The nurse contacted the provider who directed the patient to be sent to a local emergency room for diagnosis and treatment. The patient's subsequent diagnosis was determined to be constipation. In addition, it was determined the patient tested positive for amphetamines. On 12/26/18, Staff #905 conducted another room search. During the search, a white powder in a plastic bag was found in Patient #903's pant pocket. The patient was confronted and stated that the powder was Suboxone (a medication used for opioid dependence). The patient stated he had received it during an emergency room visit prior to being admitted at the psychiatric hospital. The staff had not found or detected the medication during the initial admission process. The RN placed the plastic bag in a specimen container and marked it with the patient's name, date and time found. The RN gave the item to the CNO and wrote a progress note on 12/26/18 detailing what he found in the patient's room. 4. The RN stated that he also filled out an incident report regarding the search findings. The surveyor was unable to find a incident report regarding this incident nor the incident on 12/24/18 despite a review of the hospital's incident report logs. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L 780		

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L1065	Continued From page 47	L1065		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of policies and procedures, the hospital failed to develop an individualized plan for patient care for 5 of 15 patients reviewed (Patient #501, #502, #503, #504, and #902). Failure to develop an individualized plan of care can result in the inappropriate, inconsistent, or delayed treatment of patient's needs and may lead to patient harm and lack of appropriate treatment for a medical condition. Findings included: 1. Document review of the hospital's policy and	L1065		

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L1065	Continued From page 48	L1065		

procedure titled, "Treatment Planning," no policy number, effective date 05/17, showed that following the nursing assessment, the Registered Nurse will add medical problems to be addressed to the treatment plan. The treatment plan will be reviewed and updated weekly at Treatment Team meetings and will reflect changes in the patient's course of treatment.

Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease the risk of infectious disease included addressing infectious diseases on the medical care plan.

Patient #501

2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient's medical history showed the patient underwent a gastric bypass surgery one and a half years ago. Surveyor #5 found no evidence that nutritional support was addressed in the patient's treatment plan.

3. At the time of the observation, Staff #505 confirmed the finding and stated that he would expect to see this added to the treatment plan.

Patient #902

4. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902 who was admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. An initial medical consultation on 01/06/19 by a physician (Staff #903) showed a medical diagnosis of Hepatitis C was added to

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L1065	Continued From page 49 the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C. 5. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases should be added to the treatment plan. Patient #502 6. On 01/08/19 at 3:00 PM, Surveyor #5 and the Infection Preventionist (Staff #507), reviewed the medical record for Patient #502, who was admitted for the treatment of schizo-affective disorder with methamphetamine abuse and attempted suicide. On 12/26/18, the patient was tested for Hepatitis A, B, and C related to abnormal liver function tests. On 12/31/18, the patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan. 7. At the time of the finding, Staff #507 stated that she was aware of the patient, and confirmed that staff should have added the new medical diagnosis to the medical section of the treatment plan.	L1065		

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L1065	Continued From page 50 Patient #503 8. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511) and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patient #503, who was admitted for major depression, visual hallucinations, and suicidal ideation with intent to harm oneself. An initial medical consultation completed on 01/04/19 showed a medical diagnosis of Diabetes Mellitus Type 2. On 01/04/19, a provider ordered blood glucose checks twice daily. Surveyor #5 found no evidence that the medical problem of diabetes was included in the patient's treatment plan. 9. At the time of the observation, Staff #511 confirmed the finding. Patient #504 10. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed the patient had greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800 mg 5 times daily for 7 days. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan. On 10/06/18 at 4:00 PM, a medical consultation showed the patient had a red rash to the inguinal and groin regions. The patient was treated with fluconazole 100 mg daily for 7 days and	L1065		

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L1065	Continued From page 51 antifungal powder for the treatment of intertigo (a rash caused by fungus or bacteria that usually affects the folds of the skin, where the skin rubs together, or where it is often moist) and candidiasis (a fungal infection). On 10/15/18 at 11:40 AM, a medical consult was ordered for increased redness and itching around the groin area. A provider ordered Doxycycline 100 mg daily for 7 days for intertigo. Surveyor #5 found no evidence that the medical diagnosis was included in the patient's treatment plan. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L1065		
L1080	322-170.2H DISCHARGE PLAN WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (h) A discharge plan including a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to include the family of a patient in the discharge planning process for 1 of 1 patients reviewed (Patient #515). Failure to include the family in the discharge planning process places patients at risk for	L1080		

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L1080	Continued From page 52 readmission to the hospital. Findings included: 1. Document review of the hospital's policy and procedure titled, "Discharge Planning," no policy number, effective date, 05/17 showed the discharge planning process will include timely and direct communication with and transfer of information to other programs, agencies, or individuals that will be providing continuing care. When developing aftercare plans, the hospital must consider: -Family relationships; -Physical and psychiatric needs; -Financial needs; -Housing needs and/or placement issues; -Employment needs; -Educational/vocational needs; -Social and recreational needs; -Accessibility to community resources; -Personal support systems; -Spiritual needs; -Transportation problems related to aftercare treatment; - Potential for recidivism 2. On 01/10/19, Surveyor #5 reviewed the medical record for Patient #515, who was admitted on 10/28/18 for the treatment of personality disorder, depression, anxiety, and rule out psychosis. The review showed: a. The intake assessment completed on 10/28/18 showed the patient had been living with his father, but could not return after discharge. b. Psychosocial assessment completed on 10/30/18 showed the patient is homeless.	L1080		

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L1080	Continued From page 53 c. On 11/24/18, nursing staff documented in the nursing notes that the patient's mother requested a family session to discuss the patient's "care, housing, and other things." d. On 11/25/18, a provider documented in the psychiatric progress notes that the mother requested a family session to discuss the patient's care. e. On 11/26/18, a provider documented in the psychiatric progress notes his discussion with the patient regarding discharge that included a potential option to live with his mother. The psychiatric progress note stated that the mother "needed" a family session. 3. Surveyor #5 found no evidence in the medical record that a family session or meeting with the patient's mother occurred related to the care and discharge plan for the patient as requested. 4. On 01/10/19 at 12:00 PM, during interview with Surveyor #5, a Program Therapist (Staff #515) stated that the request for a family session was not communicated and did not occur. She stated that it was the responsibility of the program therapist to set up a meeting if the family requests one and requests for these meetings should have been discussed in the treatment team meeting. Staff #515 stated that the hospital recently changed the discharge planning process and the program therapists are now responsible for doing discharge planning .	L1080		
L1150	322-180.1D PHYSICIAN AUTHORIZATION	L1150		

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L1150	Continued From page 54 WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure staff appropriately ordered the correct time limits for restraint use or seclusion based upon the patient's age for 1 of 6 records reviewed (Patient #1001). Failure to order the correct time of restraint or seclusion duration places patients at risk for physical and psychological harm, loss of dignity, and violation of patient rights. Findings included: 1. Review of the hospital's policy titled, "Use of Seclusion," no policy number, effective 05/17 showed that the use of seclusion requires a time-limited Physician order. For ages 9 -17 years old, the time duration is two hours. For those 18 and older, the time duration is four hours. The policy showed that in the event of an emergency, a trained nurse may make the decision to initiate seclusion. 2. A review of Patient #1001's medical record showed a 13-year old patient admitted to the	L1150		

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L1150	Continued From page 55 adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the patient was observed punching the wall, resulting in harm to himself as staff attempted to de-escalate the situation. The review showed that the patient initially was held manually from 2:45 PM - 2:50 PM and then placed in seclusion from 2:45 PM - 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM, but the time limit ordered for this event was noted to be for an adult with a maximum of 4 hours of seclusion. Since the patient was a 13 year old, the order should have been limited to two hours of seclusion, plus continuous assessment, by staff, to ensure release from seclusion was done at the earliest possible time, as required. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L1150		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that nurses verified that	L1165		

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L1165	Continued From page 56	L1165		

emergency supplies and equipment were available and ready for use as directed by hospital policy.

Failure to ensure that supplies and equipment are available and ready for use risks poor patient outcomes during medical emergencies

Findings included:

1. Document review of the hospital's policy and procedure titled, "Emergency Drugs and Supplies - Crash Cart," no policy number, effective 12/17, showed that the crash cart will be inspected after each use and each month to ensure completeness of contents.

Document review of the instructions for the crash cart checklist showed that night shift would check the cart daily, initial each box, and sign at the bottom of the sheet. On the first of the month, the crash cart is opened and checked for expired items.

2. On 01/08/19 at 9:35 AM during a tour of 2-North, Surveyor #3 inspected the emergency cart. A review of the emergency cart checklist logs showed that cart checks were missing for 12 of 30 days in November 2018, for 14 of 31 days in December 2018, and were missing the first 7 days of January 2019.

3. On 01/08/19 at 9:35 AM, Surveyor #3 interviewed the Program Manager (Staff #307) about the missing emergency cart checks. She stated the night shift nursing staff were responsible for performing the checks.

4. On 01/08/19 at 2:00 PM, Surveyor #5 and a Program Manager (Staff #503) inspected an

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1165	Continued From page 57 emergency cart located in the Intensive Care Unit. The observation showed missing or partial completion of cart checks for 2 of 8 days in January 2019 and 14 of 31 days in December 2018. At the time of the observation, Staff #503 confirmed the finding. .	L1165		
L1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure medical staff promptly signed and authenticated verbal or telephone orders taken by a nurse for initiation of seclusion or restraint as observed in 2 of 4 records reviewed (Patient # 303, #1001). Failure to authenticate verbal or telephone orders for initiation of seclusion risks treatment errors and violation of patient rights.	L1260		

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L1260	Continued From page 58 Findings included: 1. Document review of the hospital's policy and procedure titled, "Use of Seclusion," no policy number, effective 05/17, showed that the physician's order governs the use of seclusion and the order will include the behavior that led to the intervention. The policy showed that the orders for seclusion must be authenticated within 24 hours. Document review of the medical staff rules and regulations, approved 05/31/17, showed that seclusion and/or restraint procedures require an order from the physician. In the event of an emergency, the registered nurse can initiate the procedure but must obtain an order. Seclusion and/or restraint orders must be authenticated by the physician within 24 hours. 2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #303. Patient #303 was a 14-year old admitted on 12/01/18 for major depressive disorder. The surveyor reviewed five episodes of manual physical holds and seclusion events from 12/15/18 to 12/23/18. No physician signature could be found authenticating the telephone order received by the registered nurse for seclusion episodes that occurred on 12/20/18 and 12/21/18 in the medical record. 3. On 01/11/19 at 10:45 AM, Surveyor #10 reviewed Patient #1001's medical record that showed a 13-year old patient admitted to the adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the record showed that the patient was observed punching a wall resulting in harm to himself as staff attempted to de-escalate the situation. The	L1260		

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L1260	Continued From page 59 record showed that the patient initially was placed in a manual hold from 2:45 PM to 2:50 PM, followed by being placed in seclusion from 2:45 PM to 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM and included the behavior that led to the intervention. At the time of the review, the verbal order had not been authenticated by a licensed provider's signature as required by policy. .	L1260		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policy and procedures, the hospital staff failed to follow its procedure for transcribing physician orders to the medication administration record for 4 of 7 patient records reviewed (Patient #301, #302, #303 and #904). Failure to transcribe and process physician orders promptly places patients at risk for delayed treatment and medication errors. Findings included: 1. Document review of the hospital's policy and	L1375		

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L1375	Continued From page 60	L1375		

procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse will transcribe medication and treatment orders. Any medication order transcribed to the medication administration record (MAR) is to be checked for accuracy by a second nurse during the chart check (at shift change and 24-hour chart check). Staff will ensure a copy of all medication orders, including as needed orders, are delivered without delay to the Pharmacy mailbox.

Document review of the hospital's policy and procedure titled, "Written Medication Orders," no policy number, effective 05/17, showed that nursing staff will forward the written copy of the order to pharmacy in a timely manner.

2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #301. The review showed that on 01/02/19 at 11:59 AM, a provider wrote a medication order for Depakote (medication used for mood disorders). The medication order was transcribed to the medication administration record (MAR) and sent to the pharmacy at 8:30 PM, over eight and one-half hours after being initially ordered. As a result, Patient #301 did not receive the medication in the evening as ordered due to the pharmacy being closed.

3. On 01/09/19 at 11:15 AM, Surveyor #3 reviewed the provider medication orders for five patients. The review showed:

a. Patient #302 had seven new medication orders written by a provider between 11/26/18 and 12/31/18 in which they were not transcribed by the nurse to the medication record for greater than 3 hours. The delay in transcribing ranged

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L1375	Continued From page 61 from 3 hours and 10 minutes to 8 hours and 45 minutes. b. Patient #303 had one new medication order written by a provider on 12/13/18 at 7:00 PM but was not transcribed by the nurse until 12/16/18 at 1:00 AM, which is 2 days and 6 hours after being originally ordered. 4. On 01/10/19 at 10:40 AM, Surveyor #9 and Surveyor #11 interviewed a provider (Staff #907) regarding an allegation that Patient #904 had not received a medication as ordered and subsequently was not discharged as planned due to psychiatric decompensation. The provider stated that he ordered lorazepam 1 mg (a medication used to treat anxiety) to be administered to the patient three times a day. The original order written on 12/26/18 had an expiration date of 01/02/19. The provider stated that he reordered the medication on 01/02/19. On 01/04/19, the provider noted that the patient seemed more anxious. He reviewed her medications, looked at the patient's medication administration record (MAR), and discovered that 5 doses of lorazepam (2 days) had not been given. Further, the MAR did not reflect the renewal order for continuing the lorazepam as ordered on 01/02/19. Document review for Patient #904 showed the following: a. The MAR reflected that Lorazepam was ordered on 12/26/18 by the provider and was to be given three times a day. -On 01/01/19 to 01/02/19 the medication lorazepam was only given twice a day (due to the MAR not being transcribed correctly).	L1375		

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L1375	Continued From page 62 -On 01/02/19 to 01/03/19 the medication lorazepam was not transcribed on the MAR and therefore was not given to the patient. -On 01/03/19 to 01/04/19 the medication lorazepam was not transcribed on the MAR initially but added later after discovering the error. As a result, the patient only received the medication twice that day. - A total of 5 doses of the medication lorazepam were missed from 01/01/19 to 01/04/19. b. On 12/31/18, a reorder form for drugs expiring between 12/31/18-01/02/19 showed that the provider reordered the medication lorazepam. There were two stamped "Faxed" dates on the medication reorder form. One had no date noted and the second medication reorder form showed the order was refaxed on 01/04/19. 5. The provider stated that when he discovered this, he contacted the Chief Nursing Officer (Staff #906) and submitted an incident report to the pharmacy. Surveyor #9 was unable to find an incident report regarding this error despite a review of the hospital's Medication Error Incident Reports. 6. On 01/16/19 at 10:30 AM, Surveyor #9 discussed this finding with the Pharmacy Director (Staff #908). Staff #908 stated that he had not received an incident report on this error; however, around 01/02/19 he found that faxes were not being received in the pharmacy leading to duplications on orders. Additionally, he stated the process to verify the MAR was not clearly defined which led to errors. The Pharmacy Director (Staff #908) changed the reorder process so that	L1375		

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L1375	Continued From page 63 medication orders are now scanned to pharmacy. The scanned orders are in a database that is accessible to pharmacy, physicians, and nursing to enable clarification and avoid duplications and missed orders. THIS IS A REPEAT CITATION PREVIOUSLY CITED ON 03/15/18. .	L1375		
L1400	322-210.3H PROCED-MEDS IN PATIENT AREAS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (h) Maintaining drugs in patient care areas of the hospital including: (i) Hospital pharmacist or consulting pharmacist responsibility; (ii) Legible labeling with generic and/or trade name and strength as required by federal and state laws; (iii) Access only by staff authorized access under hospital policy; (iv) Storage under appropriate conditions specified by the hospital pharmacist or consulting pharmacist, including provisions for: (A) Storing medicines, poisons, and other drugs in a specifically designated, well-illuminated, secure space; (B) Separating internal and external stock drugs; and (C) Storing Schedule II drugs in a separate locked drawer, compartment, cabinet, or	L1400		

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L1400	Continued From page 64 safe; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of hospital policy and procedures, the hospital failed to ensure appropriate disposal of unusable medications. Failure to ensure medication storage areas are devoid of outdated or otherwise unusable medications puts patients at risk for receiving medications with compromised sterility, integrity, or stability. Findings included: 1. Document review of the hospital's policy and procedure titled, "Multi-Dose Vials," no policy number, effective date 05/17, showed that all multi-dose vials must be dated with an 28-day expiration date and initialed with the time of the original opening by the person initially accessing the multi-dose vial. 2. On 01/09/19 at 8:53 AM, Surveyor #5 and a Program Director (Staff #508) inspected the medication room on the Adult Unit. Surveyor #5 observed 2 opened partially used multi-dose vials of Diphenhydramine 500mg/mL (an antihistamine) sitting on top of the medication-dispensing machine. The bottles did not contain a label with an expiration date or the initials of the staff initialing accessing the bottle. 3. At the time of the observation, Staff #508 confirmed the finding and removed the vials. 4. On 01/09/19 at 10:15 AM, Surveyor #9 and the Program Director (Staff #902) of the Transitional	L1400		

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L1400	Continued From page 65 Care Unit (TCU) inspected the TCU medication room. Surveyor #9 found 3 opened partially used vials of Bacteriostatic Water in a cabinet. The bottles did not have a label with an expiration date or the initials of the staff who accessed the vial. 5. At the time of the observation, Staff #902 confirmed the finding and removed the vials. .	L1400		
L1470	322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services. The licensee shall: (1) Provide access to laboratory services to meet emergency and routine needs of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to ensure laboratory testing supplies did not exceed their designated expiration date. Failure to ensure testing supplies do not exceed their expiration date places patients at risk for inadequate medical treatment due to unreliable test results. Findings included: 1. On 01/08/19 at 9:35 AM during an inspection of the adolescent unit, Surveyor #3 found the following items in the medication room: a. One bottle of urine drug screening dipstick tests with an expiration date of 08/18.	L1470		

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L1470	Continued From page 66 b. One package of Streptococcal A dipstick rapid test with an expiration date of 09/30/18 c. One bottle of Streptococcal A regent 1 control agent with an expiration date of 12/28/18. d. One bottle of Streptococcal A regent 2 control agent with an expiration date of 01/04/19. e. One package of Streptococcal A controls with an expiration date of 01/04/19. f. One bottle of chemstrip urine test strips with an expiration date of 09/30/18. 2. On 01/08/19 at 10:15 AM, Surveyor #2 inspected the laboratory area of the hospital. During the inspection, the surveyor observed the following expired supplies: a. 9 BD Vacutainer UA Transfer Straw Kits with an expiration date of 05/18 b. 16 BD Vacutainer C&S Transfer Kits with an expiration date of 05/18 c. 59 UTM-RT Specimen Collection Kits with an expiration date of 11/18 d. 27 OC-Auto Personal Use Kits with an expiration date of 09/20/18 e. 1 container of Chemstrip 10 MD - Cobas UA Strips with an expiration date of 09/30/18. 3. During the observation, Surveyor #2 interviewed a facilities engineer (Staff #201) who confirmed the observations. .	L1470		

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L1475	Continued From page 67	L1475		
L1475	322-220.2 LICENSED LAB WAC 246-322-220 Laboratory Services. The licensee shall: (2) Ensure laboratory services are provided by licensed or waivered medical test sites in accordance with chapter 70.42 RCW and chapter 246-338 WAC; This Washington Administrative Code is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure staff performed quality control checks for blood sugar point of care testing as required. Failure to ensure quality control checks for point of care testing are performed risks patients receiving treatment based upon inaccurate test results. Findings included: 1. Document review of the hospital's policy and procedure titled, "Glucose Monitoring," no policy number, effective 05/17, showed that on a daily basis, the glucometer will be checked by the night shift staff using the normal control solution obtained from the manufacturer. 2. On 01/08/19 at 10:35 AM, Surveyor #3 inspected the 2-West Adolescent Unit's medication room. During the inspection, the surveyor reviewed the point of care testing blood sugar quality control record sheets. The review showed that quality control checks for the glucometer were missing for 7 of 30 days in November 2018, 11 of 31 days in December 2018, and 7 of 8 days in January 2019.	L1475		

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L1475	Continued From page 68 3. An interview with the Program Manager (Staff #307) at the time of the observation confirmed these observations. She stated the hospital policy is that glucometer quality control checks are done daily. .	L1475		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: . Based on observation and record review, the hospital failed to ensure that staff were monitoring refrigeration temperatures to ensure proper cold holding of patient food items. Failure to ensure that refrigerators maintain patient food items at proper cold holding temperatures risks food-borne illness. Findings included: 1. Record review of the hospital policy titled, "Food Storage," effective date 05/17, showed that staff are to check and record temperatures twice a day. 2. On 01/10/19 at 7:00 PM, Surveyor #2 reviewed a refrigeration log from the first floor patient refrigerator. Hospital staff had not checked or recorded the temperature since 01/01/19. Reference: Washington State Retail Food Code,	L1485		

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L1485	Continued From page 69 WAC 246-215-03525 (1) (b) .	L1485		
L1520	322-230.2G FOOD SERVICE-DIET MANUAL WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (g) Maintaining a current diet manual, approved in writing by the dietitian and medical staff, for use in planning and preparing therapeutic diets; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that the medical staff and dietician approved a diet manual per hospital policy. Failure to approve a diet manual risks patients receiving inadequate nutrition. Findings included: 1. Record review of the hospital policy titled, "Diet Manual," effective 05/17, showed that the medical director and the dietician are required to review the diet manual annually. Record review of the diet policies showed that the hospital last reviewed them on 05/17. 2. On 01/16/19, Surveyors #2 and #5 interviewed the dietician (Staff #204) regarding dietetic services. The dietician stated that she had not	L1520		

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L1520	Continued From page 70 reviewed the diet manual annually and had not reviewed it with the medical staff.	L1520		

POC Received on 04/03/19

Sign SIA Agreement Accepted in lieu of Approved POC 06/11/19

DOH Response:

L315: Policies-Treatment
Smokey Point Behavioral Hospital (SPBH) has established additional processes to ensure that patients with medical conditions or histories that require dietary consults receive the necessary quality healthcare services.

Item #1: The policy and procedure "Nutritional Service for Patients" indicates that the nurse performs a nutritional screen and initiates a dietary consult when needed.

The deficiency has been corrected by:
- RNs were reeducated on 2/7/2019 to correctly complete the nutritional screen and to appropriately order a dietary consult when indicated.
- Nutritional screenings from nursing assessments are scanned and sent to the CNO for review 3 days a week, ensuring appropriate dietary consults.

Who is responsible: CNO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- Random audit of 30 nutritional screens/month by Program Director to determine if RN completed the nutritional screen and ordered the dietary consult, when indicated.
- If the dietary consult is found to be incomplete or the dietary consult was not ordered when appropriate, the RN will be addressed by the Program Director.
- If compliance drops below 90% for two consecutive months, a new corrective action plan will be created and continued to be monitored until 90% compliance is reached for three months compliance.

Date of completion: 4/1/2019

- A new process including a new dietary consult form was created that includes the dated recommendation of the dietician, dated signature of the provider approving the recommendations, and the dated signature of the nurse transcribing the order. The form was created on 2/28/2019.
- The new form including the dietician recommendation(s) will be placed in the order section of the medical record and flagged.
- The copy of the form will be sent to the dietician once the provider signs, so the dietician will be aware of the follow through of the recommendations.
- The providers were educated on the form in the Medical Executive Committee. This included that the dietary recommendations are to be reviewed an approved or documented rationale why declined.

Who is responsible: CNO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- Audit: 30 random charts will be audited for the completion of the dietary consult form and implementation of the recommendations. The audit will be completed by the Program Directors.
- If completion falls below 90% for two consecutive months, a new corrective action plan will be created and continued to be monitored until 90% compliance is achieved for three consecutive months of compliance.

Date of completion: 4/1/2019

- The "Diet Form" was reconstructed to include the medical diagnosis and the current diet ordered. The dietician will review all the new diet forms and any changes of the form. The dietician reports to the CNO.

Who is responsible: CNO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:

- Audit: 30 random charts a month will be audited for completeness, by the Program Directors.
- If completion falls below 90% for two consecutive months, a new corrective action plan will be created and continue to be monitored until 90% of compliance is achieved for three consecutive months of compliance.

Date of completion: 4/1/19

- A Dietary Consult binder has been placed on every unit. The binder has a special form that includes date dietary consult is ordered, date consult is performed, date that the provider either approved the recommendation or documents why the provider declined to approve the recommendation, the date that the order was transcribed and the intervention was started. The CNO/designee will initial the completion of this entry.

This entry will be made if consult is indicated at admission or if a consult is required during the stay. This is indicated for medical reasons, including but not limited to:

- Change in medical diagnosis.
- Change in weight as measured through weight at time of admission and change of weekly weight of more than 10%. Patients will be weighed at a minimum of weekly.

Who is responsible: CNO/designee
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:

- Audit: A random audit of 30 charts by the Program Director will compare the dietary consult binder with the findings from the nursing assessments nutritional screening and dietary consult forms to determine that all orders have been completed.
- If completion of need for consult with follow through of dietary recommendations falls below 90% for two consecutive months, a new corrective action plan will be created and continue to be monitored until 90% of compliance is achieved for three consecutive months of compliance.

Date of completion: 4/1/19

- Nurses were reeducated to clarify all orders that are unclear or contradictory (such as a diet for a general order and a diabetic order for same patient).

Who is responsible: CNO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:

- Random audit of 30 medical records for therapeutic duplication orders, or unclear orders and an order to clarify this will be performed by the Program Director.
- If completion of orders for clarification falls below 90% for two consecutive months, a new corrective action plan will be created and continue to be monitored until 90% of compliance is achieved for three consecutive months of compliance.

Date of completion: 4/1/2019

Item #2: The attending physicians assume and accept full responsibility for the quality of the clinical care for his/her patient(s), including but not limited to precautions to be followed and labs to be drawn.

The deficiencies were corrected by:

- A protocol was developed on hypoglycemia and hyperglycemia. This was developed by the hospital medical director, CNO, medical director of the company providing internal medicine services to SPBH, and the Excellence Educator.
- The protocol includes direction for staff response to the patient's blood sugar level.
- The protocol includes guidelines for the notification of provider.
- The protocol includes instructions on how to treat high or low blood glucose levels.
- Nursing staff were educated on the new protocol on 2/11/2019 and 2/12/2019.

Who is responsible: CNO

What will be done to prevent the reoccurrence and how will it be monitored for continued compliance:

- 20% random medical records will be audited by the CNO/designee to review for diagnosis of DM, blood sugar levels, was provider notified in accordance of the protocol, and was there documentation of treatment for the hypoglycemia or hyperglycemia in accordance with the protocol.
- This audit will continue until there is a minimum of 90% compliance is achieved for three consecutive months. If compliance drops below 90% for two consecutive months, then a new corrective action plan will be created and continued, until monitoring of 90% compliance is achieved.

Date of completion: 3/9/2019

L320: Policies-Patient Rights

SPBH has corrected the process to ensure that the review and resolution of patient grievance(s) occurs with the CEO and grievance committee prior to the resolution and closing of the grievance.

The deficiency was corrected through the re-education of the grievance committee of the required procedure.

Who is responsible: PI Director

What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:

- The PI Director will compare the grievance log for closure of grievances and compare with the grievance committee minutes.
- The grievance committee minutes will be shared with the PI committee monthly.

Date of completion: 2/19/2019

L415: P&P-Annual Review

SPBH policies and procedures have been reviewed and updated appropriately.

The deficiencies have been corrected through the addition of the manual cover sheets that have been signed by the CEO, Medical Director and Governing Board. The signatures were placed following the annual review and approval from the Ad Hoc Governing Board Meeting.

As the policies change in between annual reviews the revision date or initial date is added to the individual date.

Who is responsible: CEO

What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:

- PI Committee will monitor the review of policies and procedures on a yearly basis. The final review is scheduled for every January.

Date of completion: 1/19/2019

L440: Admin-Medical Director
The Governing Board and CEO has officially documented the re-appointment of the Medical Director.

The deficiency was corrected by an Ad Hoc Governing Board meeting was held and the Medical Director was appointed, and documentation placed in his file in addition to the minutes.
Who is responsible: CEO
What will be done to prevent this from reoccurring and how it will be monitored for continued compliance:

- The CEO was reeducated that a Governing Board meeting must be called. The CEO presents the proposed medical director for appointment. Documentation must be placed in the Medical Director's file and the governing board minutes.
- The Medical Executive Committee will monitor that there is an appointed Medical Director at all times.

Date of completion: 1/19/2019

L495: Admin Rules-Perform Evals
SPBH has corrected the process to ensure the identification, tracking and investigation of patient safety events.

The deficiencies were corrected by:

- The CNO placed in the CNO Communications the description of incident reporting on 1/25/2019.
- The CNO reeducated the nursing staff on the proper procedure of completing incident reports on 2/11/2019 and 2/12/2019. Education included but was not limited to how to fill out an incident report, non-punitive approach of reporting, and using the newly implemented locked box that prevents removal of incident report. The locked box centrally locates the reports and prevents unauthorized access to the reports.
- The new process ensures the completion and secure collection of the incident reports. The incident is then placed in the variance log by the PI Director. The report is then investigated by the appropriate department head.
- Once the incidents have been properly recorded and investigated the trends are now being forwarded to the PI Committee for assessment of trends and implementation of PI activities and action plans.
- Trends in the PI Committee that have had successful plans developed include the medication review from the CNO and Director of Pharmacy, an active fall prevention program and de-escalation of aggressive behavior through CPI efforts. The mitigation plan of room checks, along with the searches, assists with the identification of possible contraband and identification of specific patients that required specific behavioral plans.

Who is responsible: Director of PI
What will be done to prevent this from reoccurring and how it will be monitored for continued compliance:

- Program Directors are reviewing incident reports and communication from their respective programs to ensure all incidents have documented reports.
- CNO, Program Directors and other Department Heads will review the variance log on a weekly basis to verify all incidents have been reported.
- 20% of medical records will be randomly audited for incidents that will be compared with the incident reports to insure all have been reported.
- The audit will continue until compliance is achieved at 90% for three consecutive months. If compliance drops below 90% for two consecutive months then a new corrective action plan will be created and continued to be monitored until 90% compliance is achieved for 3 months.

Date of completion: 3/9/2019

Item #1: Patient Safety

The deficiencies were corrected by:
- Correcting the process for identifying and reporting incident reports.
- Incident reports are completely investigated.
- Incidents are trended in PI Committee and action plans developed.
- Monthly the data is now aggregated, analyzed and presented to the PI Committee and reported in the PI Improvement Dashboard.

Who is responsible: Director of PI
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- Program Directors will aggregate and analyze incident report data and present monthly to the PI Committee.
- If incidents are noted to occur but are not on the variance log with at least a 90% compliance rate then a new action plan will be developed and monitored until there is 90% compliance for a three month period.

Date of completion: 3/9/2019

Item #2: Quality Care Assessment and Improvement.
SPBH has evaluated the performance metrics for the clinical contracted services and has reported this to the PI Committee. This includes the contracted Pharmacy Services.

The deficiencies were corrected by:
- The clinical contracted services were reviewed, and the evaluations were submitted to the PI Committee.
- The Director of Pharmacy is active in meetings individually with the CNO, reports medication errors through aggregated and trended data first in P&T Committee then in PI Committee.

Who is responsible: Director of PI is ultimately responsible for the ongoing PI process at SPBH.
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- On an annual basis in January all clinical contracts will be reevaluated (if not earlier) and presented in PI Committee.
- Pharmacy will review all medication errors, trends and analysis in P&T and PI Committees.
- If at least 90% of clinical contracted services are not in compliance with evaluations for 2019 or 2020 then a new action plan will be created and monitored yearly for 3 years.

Date of completion: 4/1/19

Item #3: Data Collection and Analysis
SPBH now documents the aggregation and analysis of data.

The deficiencies were corrected by:
- The PI Plan was reevaluated, and it was determined that the plan was appropriate. The documentation has been readjusted over the past year and it has been readjusted to be more detailed to accurately reflect the PI process.
- The person taking minutes has been instructed to be more detailed in the documentation.

Who is responsible: Director of PI
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- The minutes will be reviewed for aggregation and analysis.

Date of completion: 4/1/2019

Item #4: Quality Improvement Activities:
SPBH does identify problems, prioritize problems and develops action plans.

The deficiencies were corrected by:
- Each department identified indicators for potential problems, with identified benchmarks, targets for improvement and identified the monitoring plans.

Who is responsible: Director of PI is responsible for overall oversight.
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- All department indicators will be reviewed. If 90% of departments are not in compliance with presenting the indicators with benchmarks targets for improvement and monitoring plans, then the department head in noncompliance will be reeducated and individually monitored by the Director of PI.

Date of completion: 4/1/2019

Item #5: Adverse Event Action Plan Monitoring:
The hospital is now in compliance with monitoring action plans to determine effectiveness of interventions or measurable progress toward the established goals.

The deficiencies were corrected by:
- Having a reevaluation of the RCAs action plan evaluations.
- The medical director of the internal medicine group agreed to participate in the reevaluations.

Who is responsible: Director of PI is responsible for coordination of all PI activities.
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- All RCAs and adverse events will be discussed in PI Meeting to ensure appropriate follow up.

Date of completion: 4/1/19

Item #6: Performance Improvement Action Plans:
SPBH has taken major steps to correct all identified deficiencies.

The deficiencies were corrected initially and when similar citations were given additional plans of actions were immediately put into place to rectify all concerns. The hospital has always provided quality care and will continue to strive to provide excellence in psychiatric care, which is desperately needed in this area. Please refer to each citation for how it is specifically addressed.
Who is responsible: CEO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- The CEO is held responsible for the functioning of the hospital.
- The CEO receives direct supervision from the Governing Board.

Date of completion: 4/1/2019

L505: Provide Patient Services
SPBH has employed sufficient staff to provide patient services.

The deficiencies have been corrected by:
- The hospital staffing plan requires a minimum of one RN and sufficient staff per unit per shift.

- The Governing Board reviewed and approved on 2/27/19 that one additional RN to be placed on every shift in case of call offs.
- If a RN calls off, efforts are made to replace.
- Agency contracts are in place to cover if hospital staff are not sufficient.
- Recruitment bonuses are still in effect.
- RNs receive insurance for free.
- All staff have been requested to give any suggestions on how SPBH can retain and recruit good staff. This was done as recently as 3/26/2019 in town hall meetings.

Who is responsible: CEO
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- Interviews and hiring continues.
- Staffing is scheduled to include sufficient staff.
- HR department will provide a turnover rate report monthly to the PI Committee.

Date of completion: 4/1/2019

L545: Orientation-Org
SPBH has corrected the orientation process and documentation in agency files. All staff are oriented appropriately prior to working. Agency staff files have been reviewed to verify that the orientation has occurred and is appropriately documented.

The deficiencies have been corrected by the Director of HR, who has reviewed 100% of current agency files.
- A checklist is now included in the files.
- Minimum of orientation now exists for workplace harassment, environment of safety, hazard communication, patient rights, abuse and neglect, HIPAA, cultural, age and SUD competency, EMTALA, therapeutic boundaries, codes, and infection control.

Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- HR reviews all files and has a tool to ensure all training has been completed prior to an employee working a shift.
- HR will review the tickler system on a minimum of monthly basis to ensure all trainings and orientation are current and complete.
- HR Department will provide a compliance report to the PI Committee monthly.

Date of completion: 4/1/2019

L550: Orientation-Physical Layout
SPBH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
- Documentation of the orientation of the agency staff to the physical layout and to the physical layout of the hospital places where patients at risk for inadequate care. All staff are required to have orientation.

Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- HR reviews employee files and has set up a tickler system to ensure all training has been completed prior to working a shift.
- HR will review the tickler system on a monthly basis to ensure all trainings and orientation are current and complete.

• HR Department will provide a compliance report to the PI Committee monthly.
Date of completion: 3/27/2019

L555: Training-Disaster Plans
SPBH has corrected the orientation process and documentation in agency files. All staff are required to have orientation.

The deficiencies have been corrected by:
• All agency employees have been trained on the fire and disaster plan of the hospital and documentation in the file.
Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
• HR reviews files and has a tracer tool to ensure all training has been completed to an employee before working a shift.
• HR will review this tracer on a monthly basis to ensure all trainings and orientations are up to date and complete.
• HR department will provide a compliance report to PI Committee monthly.
Date of completion: 3/27/2019

L560: Training-Infection Control
SPBH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
• Documentation orientation of the agency employee to Infection Control. All staff are required to have this orientation.
Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
• HR reviews employee files and has set up a tickler system to ensure all trainings and orientation are completed before working a shift.
• HR will review the tickler system monthly to ensure all trainings and orientations are up to date and complete.
• HR department will provide a compliance report to the PI Committee monthly.
Date of completion: 3/27/2019

L565: Orientation-Duties
SBPH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
• Documentation of the orientation of the agency employee on job duties and responsibilities. All staff are required to have this orientation.
Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
• HR reviews employee files and has set up a ticker system to ensure all trainings and orientation are completed before working a shift.
• HR will review the tickler system monthly to ensure all trainings and orientation are up to date and complete.
• HR department will provide a compliance report to the PI Committee monthly.
Date of completion: 3/27/2019

L570: Orientation-P&P
SPBH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
- Documentation of orientation of the employee for P&Ps and equipment necessary to perform job duties. All staff are required to have this documentation.

Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- HR reviews employee files and has set up a tickler system to ensure all trainings and orientation are completed before working a shift.
- HR will review the tickler system monthly to ensure all trainings and orientation are up to date and complete.
- HR department will provide a compliance report to the PI Committee monthly.

Date of completion: 3/27/2019

L575: Orientation-Patient Rights
SPBH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
- Documentation of orientation of the agency employee to patient rights according to 71.05 RCW and 71.34 RCW and patient abuse. All staff are required to have this orientation.

Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- HR reviews employee files and has set up a tickler system to ensure all trainings and orientation are completed before working a shift.
- HR will review the tickler system monthly to ensure all trainings and orientation are up to date and complete.
- HR department will provide a compliance report to the PI Committee monthly.

Date of completion: 3/27/2019

L585: Orientation-Appropriate Training
SPBH has corrected the orientation process and documentation in all current agency files.

The deficiencies have been corrected by:
- Documentation of orientation and training of the agency employee. All staff are required to have this orientation.

Who is responsible: Director of HR
What will be done to prevent the reoccurrence and how it will be monitored for continued compliance:
- HR will review employee files and set up a tickler system to ensure all trainings and orientation are complete before working a shift.
- HR will review the tickler system monthly to ensure all trainings and orientation are complete and up to date.
- HR department will provide a report to the PI Committee monthly.

Date of completion: 3/27/2019

L590: Inservice Ed-Update

SPBH has ongoing in-service education and training to maintain and update competencies needed to perform assignments, including for agency staff.

The deficiency was corrected by:
- Documentation in the agency employee file of in-service education. All staff are required to complete mandatory in-services specific to job functions and maintain competencies.

Who is responsible: Director of Human Resources
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- HR will review employee files and set up a tickler system to ensure all ongoing in-service education have been completed and competencies maintained on an ongoing basis.
- HR will review the tickler system monthly to ensure all mandatory in-services and competencies are current.
- HR department will provide a report to the PI Committee monthly.

Date of completion: 3/27/2019

L595: Inservice Ed-Staff
SPBH has ongoing, documentation of the in-service education in the file for all current direct care staff including but not limited to: methods of patient care using the least restrictive alternatives, including restraints and seclusion, current CPI certification, and current CPR certification.

The deficiency was corrected by:
- Documentation being in place in the agency staff's file, including required certifications.

Who is responsible: Director of HR
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- HR will review employee files and set up a tickler system to ensure all mandatory certifications and in-services are on file.
- HR will review the tickler system monthly to ensure all mandatory certifications and trainings are documented in the file and are current.
- HR department will provide a report to PI monthly.

Date of completion: 3/27/2019

L670: Records-Performance Evaluations
SPBH maintains employee files including 90-day evaluations, and annual performance evaluations for all current employees appropriately.

The deficiency was corrected by:
- Requiring all staff evaluations being required in the employee files. These have been updated and placed in current files.

Who is responsible: Director of HR
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- HR will provide each department head with the annual evaluation due date the month prior to the due date.
- Department Heads will be held responsible to complete all evaluations on a timely basis.
- Each contract has a specific evaluation either in the actual contract or the addendum to the contract.
- HR will report to the CEO if evaluations are not completed on time.

- HR will report to the PI Committee as a dashboard item of annual evaluations due. Items will have a numerator (completed on time) and a denominator (total number of evaluations due for the month).

Date of completion: 3/9/2019

L720: Infection Control-Precaution
SPBH has taken immediate action to ensure that staff members place standard precautions specific to the prevention of transmission of infections.

Item #1: Herpes Zoster

The deficiency has been corrected through education:
- Of all nurses on completion of Nursing Assessment, review of H&P documentation, follow through on physician orders including isolation precautions, notification of the Infection Control Coordinator by completion of the Suspected Infection Control Form and completion of MTP. This education occurred on 2/11/2019 and 2/12/2019.
- Of medical providers on the need to order appropriate isolation precautions upon diagnosing a patient with an infection. Providers were also educated to document any infection diagnosis on the Medical Consult Log for follow up by the Infection Control Coordinator. Education performed 2/5/2019.

Who is responsible: Infection Control Coordinator.
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- Infection Control Coordinator reviews all suspected Infection Reports and investigates to ensure that proper precautions are being followed.
- Infection Control Coordinator reviews the Medical Consult Log for newly diagnosed infections.
- Director of Pharmacy gives list of all antibiotics ordered to the Infection Control Coordinator.
- HR reviews tickler system on a monthly basis to ensure training for all required staff has been documented.
- Infection Control Coordinator will report compliance with implementing medical treatment plans and isolation precautions to the quarterly Infection Control Committee Meeting.

Date of completion: 2/13/19

Item #2: Hepatitis C

SPBH has corrected the deficiency through education:
- Nurses were educated on making sure that medical diagnosis are added to the patient's problem list and MTP.
- Nurses were educated to follow precautions ordered by physician, but to also notify the Infection Control Coordinator to ensure that the patient is on proper precautions.

Who is responsible: Infection Control Coordinator
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- Infection Control Coordinator reviews all Suspected Infection Reports and investigates to ensure that the proper precautions are followed.
- Infection Control Coordinator reviews the Medical Consult Log for newly diagnosed infections.
- Infection Control Coordinator will report compliance with implementing medical treatment plans and isolation precautions to the quarterly Infection Control Coordinator.

Date of completion: 2/13/19

L765: Infection Control Meetings

Infection Control Meetings are now held at SPBH at a minimum of quarterly.

The deficiency was corrected by:
- An Infection Control Coordinator is appointed for the hospital.
- Infection Control Committee will be held on the scheduled day and if key staff members are absent, other qualified staff will fill their positions in the meeting.
- The Infection Control Committee met immediately after the survey to get back in compliance.

Who is responsible: Infection Control Coordinator
What will be done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- The meeting is prescheduled for the year in the calendar and the calendar has been distributed.
- The Administrative Assistant will send out the invites.
- Infection Control Committee Minutes will be provided to PI Committee on a quarterly basis.

Date of completion: 2/13/2019

L780: Safe Environment
SPBH has taken steps to ensure the safety of the patients through searches of the patient and their belongings. Any contraband found at any time is confiscated immediately. Tools are utilized to assist in the search for contraband, including wanding. Safety monitoring is always a priority.

The deficiency was corrected by:
- Patients are searched upon admission, and skin checks and room checks are conducted in order to mitigate possible events of contraband on the unit.
- The CNO provided communication on 1/25/2019 through the CNO Communication describing the process for incident reporting. A sample incident report was placed in a red folder for staff to use as a model for completing incident reports.
- The CNO reeducated the nursing staff on the proper procedures of reporting incidents on 2/11/2019 and 2/12/2019.
- A new secure drop box was created for all incident reports.
- Incidents are placed in the variance logs by the Director of PI.
- The incidents are analyzed, trended and action plans developed in PI Committee.

Who is responsible: Director of PI
What will be done to prevent the reoccurrence and how is it to be monitored for continued compliance:
- Program Directors will review incident reports and communicate with programs to ensure all incidents are reported.
- CNO, Program Directors, and other Department Heads will review the variance log on a weekly basis to ensure all incidents have been reported.
- If variances are found staff will be reeducated. If non-compliance is continued then a new corrective action plan will be created.
- 20% of medical records from 2/28/2019 going forward will be audited weekly. This audit will continue until 90% compliance for 3 months is achieved.
- If compliance drops below 90% for two consecutive months then a new corrective action plan will be created and continued to be monitored until 90% at 3 months compliance is achieved.

Date of completion: 4/1/2019

L1065: Treatment Plan-Comprehensive
SPBH is now developing an individualized plan for each patient.

The deficiency was corrected by:

- RNs were reeducated on the proper procedures of completing MTPs on 2/11/19 and 2/12/2019. The education included but was not limited to purpose of treatment plans, how to fill out a comprehensive MTP, review of MTPs and adding additional medical or psychiatric problems to the MTP.
- Sample MTPs were created for new employee orientation to teach and review sample plans.

Who is responsible: CNO

What will be done to prevent reoccurrence and how is it to be monitored for continued compliance:

- During treatment teams, each patient will be reviewed to identify any new and ongoing psychiatric and/or medical issues that are being treated or deferred. Each issue will be placed on the treatment plan accordingly.
- 20% of medical records will be audited monthly. This audit will evaluate completeness of MTPs. This audit will continue until 90% compliance is achieved for 3 months. If compliance falls below 90% for two consecutive months a new corrective action plan will be created and audited until 90% compliance is reached for 3 months.
- Program Directors, Directors of Clinical Services and or CNO will audit new admissions within 72 hours for compliance with completeness of all issues.
- If the MTP is not complete the treatment team will be addressed to reeducate to include medical and psychiatric.
- Monthly reports will be presented to PI Committee via the PI dashboard.

Date of completion: 3/9/2019

L1080: Discharge Plan

SPBH is now including the family whenever allowed by HIPAA, and ability to connect with families. This is the goal whenever allowed by the patient.

The deficiency was corrected by:

- Education of therapists that family participation needs to be encouraged, with permission from patient as appropriate. The therapists were reeducated on the proper procedures for contacting and conducting family sessions as it relates to the patient's care and discharge planning. Education included but was not limited to: purpose of family sessions, expectation of obtaining release of information, treatment team discussions about family involvement, where to place documentation in the medical record about the family sessions as applicable. This education was provided on 2/6/2019.

Who is responsible: Director of Clinical Services

What will be done to prevent reoccurrence and how is it to be monitored for continued compliance:

- Program directors will randomly audit 30 charts a month to ensure documentation of attempts to contact families and involve families in discharge planning.
- Noncompliance with involving families in discharge planning, when allowed by the patient, will be addressed with re-education.
- Monthly reports of the weekly data will be presented to the PI Committee via the 2019 Performance Improvement Dashboard.

Date of completion: 2/13/2019

L1150: Physician Authorization

SPBH is now ensuring that the staff appropriately order the correct time limits for restraint and seclusion.

The deficiency was corrected by:

- The Medical Director reeducated the Medical Staff on ordering restraint/seclusion maximum time limit according to age limitations. This training occurred on 2/28/2019.
- The CNO reeducated the nurses on Restraint/Seclusion documentation completion on 2/11/2019 & 2/12/2019. This was educated with a tool provided by the CNO. All nurses had training documented no later than 3/1/2019.
- The Restraint/Seclusion Order Sheet was amended to include the correct maximum time for adolescents and adults with a check box for the provider.

Who is responsible: CNO
What will be done to prevent reoccurrence and how it is to be monitored for continued compliance:

- Program Directors will audit all Restraint Seclusion forms for completeness.
- Program Directors will submit the audits weekly to the CNO.
- The CNO will present the data analysis to the PI Committee monthly.
- Any nurse making errors will be reeducated by the CNO.
- 100% of Restraint/Seclusion paperwork from 2/28/2019 going forward will be audited. If the compliance level with completeness drops below 90% for two consecutive months, then a new corrective action plan will be created and will continue to be monitored until 90% at 3 months compliance is achieved.

Date of completion: 3/1/2019

L1165: Emergency Supplies
SPBH ensures that emergency supplies and equipment were available and ready for use.

The deficiency was corrected by:

- A monitoring checklist was created for supervisors to review supplies for presence and expiration dates. Any expired supplies will be destroyed.
- A policy regarding expired supplies was created.
- Staff were educated on looking for expired supplies and what to do once found.
- The Program Directors organized their respective units and checked for any expired supplies on 1/30/2019.
- Expiration dates will be checked when being brought to the unit.
- Supplies will be organized by bringing forward the supplies to expire first.

Who is responsible: CNO
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:

- The log will be provided to the CNO by the Program Director including breakdown of the amount of expired supplies found on the unit.
- The CNO will report to the PI Committee for at least 3 months.
- If the logs continue to find expired supplies on the unit for two consecutive months then a new corrective action plan will be developed.

Date of completion: 3/9/2019

L1260: Records-Signed Orders
SPBH is now ensuring that medical staff promptly sign and authenticate verbal or telephone orders taken by a nurse for initiation of seclusion or restraint.

The deficiency was corrected by:

- Reeducation of 100% of nurses on Seclusion/Restraint paperwork with the need of the provider to sign within 24 hours. Education was received on 2/11/2019 & 2/12/2019. Any unavailable staff were required to complete the education prior to their next shift, and no later

than 3/1/2019. Reeducation of nurses also included that all TORB orders must be signed within 24 hours.
- Medical Staff were reeducated on authentication deadlines of 24 hours in the 2/28/2019 Medical Staff Meeting.

Who is responsible: CNO
What will be done to prevent reoccurrence and how it is to be monitored for continued compliance:
- Nurses will remind the next staff to obtain the provider's signature.
- The Program Director will report to the Medical Director the providers that did not sign within the required 24 hours.
- The Medical Director will refer the provider for peer review for trends in not signing orders appropriately.

Date of completion: 3/9/2019

L1375: Procedures-Administration of Medications
SPBH is now in compliance with transcription and processing physician orders.

The deficiency was corrected by:
- Nurses were retrained by 2/12/2019 that all medication orders must be transcribed and scanned to the Pharmacy within 2 hours of the order being written.
- Remote entry has been implemented. Orders are now verified and processed 24 hours a day.

Who is responsible: CNO
What will be done to prevent reoccurrence and how is it to be monitored for continued compliance:
- Random medical record audits of 20% of charts monthly will be reviewed for transcription and processing of Provider Orders.
- The CNO will address any nurse concerning non-compliance with processing of orders.
- Order transcription and processing rate will be submitted to PI Committee for a minimum of 3 consecutive months at 90% compliance rate. If the compliance rate is not at 90% compliance for 2 consecutive months will have a new corrective action plan completed.

Date of completion: 2/13/2019

L1400: Procedures-Meds in Patient Areas
SPBH now ensures the appropriate disposal of unusable medications.

The deficiency was corrected by:
- Nurses were reeducated on appropriate labeling of multi-dose vials.
- Program Directors have been assigned to check accuracy of the labels.

Who is responsible: CNO
What will be done to prevent reoccurrence and how it is to be monitored for continued compliance:
- Program Directors will turn their checklists into the CNO.
- The CNO will review the checklist to ensure completion.
- Nurses write the expiration date of 28 days after opening multi-dose vials.
- Multi-dose vials will be monitored by the Program Directors starting 2/28/2019. The audit will continue until all vials are properly labeled for 3 consecutive months. If there are errors for two consecutive months a new corrective plan will be developed.

Date of completion: 3/9/2019

L1470: Lab Access
SPBH now ensures that lab testing supplies do not exceed their designated expiration date.

The deficiency was corrected by:
- Creation of a checklist for the supervisor to use while reviewing supplies for expiration dates. Any expired supplies will be destroyed.
- A policy regarding expired supplies was created during the survey.
- Staff were reeducated on looking for expired supplies and disposing of any that are found.
- Each unit was organized by the Program Directors, with expiration dates nearing first and any expiring within a month disposed of. This was completed 1/30/2019.
- Supplies being brought to the unit will be checked for expiration dates.

Who is responsible: CNO
What will be done to prevent reoccurrences and how is it to monitored for continued compliance:
- The Program Directors will give the logs to the CNO including the listing of expired supplies.
- The CNO will report to the PI Committee for at least 3 months if any expired supplies are found. If expired supplies are found for two consecutive months then a new corrective action plan will be created.

Date of completion: 3/9/2019

L1475: Licensed Lab
SPBH is now in compliance with waived testing.

The deficiency was corrected by:
- The glucometer quality control checks are being completed daily and the logs are being reviewed by the Program Directors. Any variances will be immediately reported to the CNO.
- Disciplinary action will be taken for breeches in the quality checks.
- The nurses were reeducated on the requirement of performing daily glucometer quality control checks.

Who is responsible: CNO
What will be done to prevent reoccurrence and how is it to be monitored for continued compliance:
- Program Directors will submit checklists to CNO.
- CNO will aggregate and analyze the data and present to the PI Committee for 3 straight months. If there are any absences for two consecutive months a new corrective plan will be created.

Date of completion: 3/9/2019

L1485: Food Service Regulations
SPBH now ensures that staff are monitoring refrigeration temperatures to ensure proper cold holding of patient food items.

The deficiency was corrected by:
- 100% of nursing staff were reeducated on the daily patient food refrigerator check documentation requirements.
- Daily refrigerator checks were added to the Program Directors checklist.
- Dietary staff were also reeducated on the daily requirement to document refrigerator temperatures.
- Dietary and Nursing staff were also reeducated on steps to take if the food temperature is outside the expected norms.

Who is responsible: CNO
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:

- The CNO will provide a monthly report to the PI Committee for a minimum of three consecutive months.
- If there is an absence of checks for two consecutive months a new corrective action plan will be created.

Date of completion: 2/13/2019

L1520: Food Service-Dietary Manual
SPBH will maintain approval of a current diet manual.

The deficiency was corrected by:
- The Diet Manual has been resigned for the Annual approval by the Medical Director, Dietician and CNO.

Who is responsible: Dietician
What is done to prevent the reoccurrence and how it is to be monitored for continued compliance:
- The signature page will be presented to the PI Committee on an annual basis.

Date of completion: 2/8/2019