State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	C 10/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

(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 COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 322-020 Psychiatric Hospitals, conducted this health and safety investigation. Onsite dates: 10/01/2018 Examination/Case number: 2018-11696 Intake number: 84382 The investigation was conducted by: Surveyor #27347 There was a violation found pertinent to this complaint.	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. PLAN OF CORRECTION DUE: OCTOBER 14, 2018 4. The Administrator or Representative's signature is required on the first page of the original. 5. Return the original report with the required signatures.	
L1110	322-170.3D SOCIAL WORK SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (d) Social work services coordinated and supervised by a social worker with experience working with psychiatric patients, responsible for: (i) Reviewing social work activities; (ii) Integrating social work services into the comprehensive treatment plan;	L1110		

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L1110	Continued From page 1 and (iii) Coordinating discharge with community resources; This Washington Administrative Code is not met as evidenced by: Based on interview and review of hospital documents the hospital failed to inform the community social worker working with a patient (Patient #1) about the discharge of the patient. Failure to inform all the community resources working with the patient about their discharge plan for the patient puts patients at risk for not having a successful discharge. Findings include: 1. The hospital policy titled "Discharge Planning", revised 05/2018 read in part "The Social Services Coordinator will attempt to involve patients and their care givers/supportive person (s) in all aspects of the discharge planning process". 2. Patient #1 record revealed the patient was admitted to the facility on an involuntary hold. On 07/06/2018 the court removed the involuntary hold. The patient demanded they leave the treatment facility after the involuntary hold was removed. The hospital tried to educate the patient about the need for further treatment but the patient left against medical advice on 07/06/2018. There was documentation that the hospital did inform the patient's outpatient psychiatric care provider and the patient's sister about the patient leaving treatment against medical advice. The hospital did set up medication for the patient to pick up at an outpatient pharmacy. The hospital did not however notify the patient's	L1110		

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L1110	Continued From page 2 community social worker listed on their patient fact sheet about the discharge of the patient on 07/06/2018. There was documentation that the community social worker called the hospital on 07/09/2018 to inquire about the patient. The social services representative then informed the community social worker on 07/09/2018 the patient had been discharged on 07/06/2018. 3. On 10/01/2018 at 11:00 AM, Staff #1 was interviewed. Staff #1 stated that they notified the outpatient psychiatric provider and family about the patient's discharge on 07/06/2018. Staff #1 stated they received a phone call on 07/09/2018 from the community social worker inquiring about the patient. Staff #1 then informed the community social worker the patient had been discharged on 07/06/2018. 4. On 10/01/2018 at 11:30 AM, Staff #2 was interviewed and verified the above information.	L1110		

Navos
Plan of Correction for
Complaint Investigation
#2018-11696/84382
October 2, 2018

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance
L1110	**Findings:** 1. The hospital policy titled "Discharge Planning" revised 05/2018 read in part "The Social Services Coordinator will attempt to involve patients and their care givers/supportive person(s) in all aspects of the discharge planning process. 2. Patient #1 record revealed the patient was admitted to the facility on an involuntary hold. On 7/6/2018 the court removed the involuntary hold. The patient demanded they leave the treatment facility after the involuntary hold was removed. The hospital tried to educate the patient about the need for further treatment but the patient left against medical advice on 7/6/2018. There was documentation that the hospital did inform the patient's outpatient psychiatric care provider and the patient's sister about the patient leaving treatment against medical advice. The hospital did set up medication for the patient to pick up at an outpatient pharmacy. The hospital did not however notify the patient's community social worker listed on their patient fact sheet about the discharge of the patient on 7/6/2018. There was documentation that the community social worker called the hospital on 7/9/2018 to inquire about the patient. The social services representative then informed the community social worker on 7/9/2018 the patient had been discharged on 7/6/2018. 3. On 10/1/2018 at 11:00 AM, Staff #1 was interviewed. Staff #1 stated that they notified the outpatient psychiatric provider and family about the patient's discharge on 7/6/2018. Staff #1 stated they received a phone call on 7/9/2018 from the community social worker inquiring about the patient. Staff #1 then informed the community social worker the patient had been discharged on 7/6/2018. 4. On 10/1/2018 at 11:30 AM, Staff #2 was interviewed and verified the above information.	Terry McInerney Hospital Administrator	10/26/18	98%

	Corrective Action Plan: Social Service Coordinators will attempt to involve all of the patients care givers/supportive person (s) in all aspects of the discharge planning. The social services director will provide education to all social service coordinators on the need to communicate with all care providers concerning on-going care and discharge planning. The social services director will audit 25% of all discharges for compliance.			