Behavioral Health Facility Investigation Report

Department of Health
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Rainier Springs 2805 NE 129th Street Vancouver, WA 98686-3324 .cility Name and Address		Jeff Serrano Administrator
Investigation Inspection Type	September 24, 2019 – October 1, 2019 Investigation Onsite Dates	JAMC3, 33894 Investigator
2019-10764, 2019-10497, 2019-11556, 2019-12018, 2019-10936 Case Number	BHA.FS.60888597 License Number	Substance Use Disorder Mental Health BHA/RTF Facility Services Type

Please note that the deficiencies/violations/observations noted in this report are not all-inclusive, but rather were deficiencies/violations/observations that were observed or discovered during the on-site investigation.

eficiency Number and Rule Reference	Observation Findings	Plan of Correction
WAC 246-341-0410(2)(c) The administrator must: (c) Employ sufficient qualified personnel to provide adequate treatment services and facility security.	Based on interview, and record review, the administrator failed to employ sufficient qualified personnel to provide adequate treatment services and facility security, for 6 of 10 patient clinical records reviewed (Patient #3, #4, #5, #6, #8, and #9). Failure to employ sufficient qualified personnel to provide adequate treatment services and facility security can result in a lack of patient care and an unsafe environment for staff and patients.	

	Findings included: 1. During an interview on 09/25/19 at 6:00 PM, Staff E, Registered Nurse (RN), stated "we leave a nurse on a unit with 20 patients when a code 100 [call for staff to assist with escalating behavior] is called on another unit. I came from jail nursing and it was a much safer job. We have been pushing for more security, they [management] have refused". 2. Review of Patient #2 "Progress Note", dated 07/26/19, showed that staff reported to the Director Of Nursing that they were unable to reach a provider to get an order for an involuntary medication when the patient's behavior was escalating. The progress note showed that the Director of Nursing directed staff to continue to attempt to contact a provider for the order, and to prepare the involuntary medication. 3. Review of Patient #2 "Seclusion and Restraint Staff Debriefing Form", dated 8/5/19, lists "not enough staff available" as the explanation for an inadequate response time to a Code 100. The document showed the code 100 was called after staff were assaulted by Patient #2. 4. review of the group notes for Patient #3, #4, #5, #6, #8, #9 showed the following: a. Review of Patient #3 group notes showed that group therapy was cancelled due to lack of staff available on 08/31/19 at 10:30 AM. b. Review of Patient #4 group notes showed that group therapy was cancelled due to lack of staff available on 8/31/19 at 2:00 PM, 9/2/19 at 9:00 AM, 9/2/19 at 1:00 PM, and 9/5/19 at 10:45 AM. c. Review of Patient #5 group notes showed that group therapy was cancelled due to lack of staff available on 05/4/19.	

	d. Review of Patient #6 group notes showed that group therapy was cancelled due to lack of staff available on 9/26/19. e. Review of Patient #8 group notes showed that group therapy was cancelled due to lack of staff available on 8/24/19 and 8/26/19. f. Review of Patient #9 group notes showed that group therapy was cancelled due to lack of staff available on 9/11/19 at 2:00 PM, and 9/13/19 at 2:00 PM. 4. During an interview on 09/24/19 at 10:00 AM, Staff B, Mental Health Therapist, stated, "I haven't been here a super long time, but I know our department is short staffed. I struggle to give the care that I am ethically wanting to give patients. I have hopes that we will have more staff soon". 5. During an interview on 9/25/19 at 10:00 AM, Staff I, Interim Director of Quality and Director of Assessment, stated that there was an increase in patients leaving against medical advice after the Medical Director stopped working at the facility on July 11, 2019 and started working remotely for the facility thorough telehealth [providing services to clients through telecommunication technologies]. Staff I also stated "When Dr. Semis left, we did not have the Doctor that could prescribe subutex [medication used to treat opioid addiction] for a period of time".	
WAC 246-341-1126(1)(e) In addition to meeting the facility licensure, certification, administration, personnel, and clinical requirement in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WAC 246-341-1118 through 246-341-1132, an inpatient facility must implement all the following administrative requirements: (e) Adequate numbers of staff present at all times that are trained in facility security	Based on document review, and interview, the facility failed to maintain adequate number of staff present at all times that are trained in facility security measures, to include de-escalation techniques for 1 of 9 patient's reviewed (Patient #1). Failure to maintain adequate number of staff present at all times that are trained in facility security measures can result in an unsafe environment for staff and patients.	

measures.	Findings included: 1. Review of the facility's policy and procedure, titled "Plan for the Provision of Nursing Care in Psychiatric Specialty Areas", dated 07/2019, showed that there is a procedure in place to evaluate and maintain nursing staff. This document, however does not address the staffing of mental health and substance use disorder staff such as Substance Use Disorder Professionals, Mental Health Therapists, or other non-nursing staff. 2. During an interview on 9/24/19 at 9:30 AM, Staff A, Director of Nursing, stated "we hire people with psychiatric experience and people that do not have experience. The CPI training [nonviolent crisis intervention] is a good initial course, we require staff to do the training during the first week they are here. We sent out a safety survey several months ago. This was part of the initiative that came out of that survey". 3. Review of CPI Training Manual, titled "Instructor Guide Nonviolent Crisis Intervention Foundation Course", dated May 2018, page 7, showed that Comprehensive Nonviolent Crisis Intervention Foundation Training Program classroom delivery time is supposed to be 12-14 hours. However, the CPI training manual states "Abridged training may significantly limit or eliminate physical intervention skills with classroom delivery time of 6-8 hours". 4. Review of facility training records showed that the facility is only conducting an 8 hour initial CPI training as part of employee orientation. 5. Review of the facility training calendar for July 2019, titled "Training Room RAI" [a printed out outlook calendar for the training room schedule], showed a hand written note on the calendar that states "NEO [new employee orientation] 8 Hour Training, CPI recommends 2 days but their class size is 40	

	participants". 6. During an interview on 9/25/19 at 6:00 PM, staff E, Registered Nurse, stated "We have patients attacking us, hot liquids thrown on us. The CPI training is not going to work. Things are happening so quickly, doing a hold is not enough to work". 7. During an interview on 10/1/19 at 10:00 AM, Staff I, Interim Director of Quality and Director of Assessment, stated when asked about the amount of CPI training time that staff were given, "Muscle memory is important. I really feel like a full day of de-escalation and a day of hand on technique would be a good initial training". Staff I also stated "I would love to change our CPI, I talked to leadership, we need to do CPI more often". 8. During an interview on 09/16/19 at 1:00 PM, Staff L, former Director of Environmental Care, stated "I did an initial CPI training and I did not do any additional training. I brought up my concerns around staff and Patient safety to the CEO, David Jones. I left because it was not addressed. My staff worked with or near patients. Safety was an issue. My staff did not feel safe". 9. During an interview on 9/16/19 at 4:15 PM, Staff O, Registered Nurse {RN}, stated, "When the doctor was assaulted, there was clearly a lack of understanding of what to do when a code 100 is called" [referring to the 09/11/19 incident involving a patient assaulting a Medical Provider, resulting in the Medical Provider being transported to the hospital]. 10. Staff interviews and document review regarding a restraint and involuntary medication administration incident on 03/13/19 for Patient #1 showed that the facility lacked sufficient qualified personnel to provide adequate treatment services and facility security based on the following:	

	a. "Risk Management Incident Report", dated 03/14/19, stated "Patient became increasingly agitated, swearing... as patient continued to verbalize these kinds of threats, she would often step into someone's personal space. Patient proceeded to kick and hit the walls, windows, and doors, demanding release; she actually kicked the door leading to the smoking area outside forcefully enough to make it bow outward. At one point, she removed her shirt, moving about the community area with her bra exposed. Patient unable to be redirected, or engaged in meaningful interaction of any sort. Several peers frightened by her behavior. In the absence of a plan to address this behavior, decision made by those present to allow the therapist [staff K] to take the patient outside to smoke a cigarette...Patient still agitated, angry, threatening upon return to unit. Code 100 paged, and order provided by Doctor Kenneth Lai for [IM] emergency medication". b. Review of a progress note for Patient #1, dated 3/13/19, at 3:59PM, stated "Staff, RN, Nurse Manager, and DON [Director of Nursing] approached patient explaining that we had an injection to give her to assist in calming her. Patient became even more agitated, kicking and hitting staff. Patient was physically restrained in a supine position on her bed by five staff members and myself and a nurse manager observing". c. In an interview on 9/16/19 at 4:00 PM, Staff Q, Advanced Registered Nurse Practitioner (ARNP), stated that the event on 03/13/19 took a long time. Staff Q stated he witnessed "four grown men pulling on the patient's arms trying to get her off the bed". Staff Q also stated that while this was occurring, he and another staff were trying to manage the milieu. Staff Q reported that the nurse had the wrong needle, and had to go get a new one, and a needle broke. Staff Q stated, "when the need for forced medication occurred, there were visitors and dogs on the floor. Staff were going to do the procedure without clearing the milieu first". Staff Q reported that he had to bring the need for clearing the milieu to the staff's attention.	

WAC 246-341-0420(5)(a) Each facility licensed by the department to provide any behavioral health service must develop, implement, and maintain administrative policies and procedures to meet the minimum requirements of this chapter. The policies and procedures must demonstrate the following, as applicable: (5) Interpreter services for individuals with limited-English proficiency (LEP) and individuals who have sensory disabilities. Documentation that demonstrates the facility's ability to provide or ıordinate services for individuals with LEP and individuals who have sensor disabilities. This means: (a) Certified interpreters or other interpreter services must be available for individuals with limited-English-Speaking proficiency and individuals who have sensory disabilities.	Based on record review and interview, the facility failed to implement policies and procedures to demonstrate that certified interpreters are available for a patient who has a sensory disability, for 1 of 9 patients reviewed (Patient #2). Failure to implement policies and procedures to demonstrate that certified interpreters are available for individuals who have sensory disabilities can result in treatment barriers that result in inadequate patient care and a violation of patient rights. Findings Included: 1. Review of Patient #2 "Psychosocial Assessment", dated 7/27/19, showed that "Patient is deaf and needs an interpreter". 2. Review of Patient #2 "Multidisciplinary Treatment Plan", dated 7/27/19, showed that staff noted that "patient is deaf and needs an interpreter" and classified it as "a high risk issue". 3. Review of Patient #2 "Psychiatric Inpatient Progress Note", dated 8/4/19, showed that an interpreter was not present for session with Provider, the Provider wrote, "This patient was seen without an interpreter. He is deaf, and the interpreter could not be located". The provider also wrote, "Requested interpreter be present for psychiatric visits". 4. Review of Patient #2 "Psychiatric Progress Note" dated 8/10/19, showed that an interpreter was not present for session with Provider. The Progress Note stated "did not have an interpreter present, we did communicate with notes" [used hand written notes to communicate with the patient]. 5. Review of Patient #2 "Sunday AM Mental Wellness Note",	

	dated 8/11/19, showed that the staff noted that the Patient could not complete the activity sheet due to the lack of an interpreter. 6. Review of Patient #2 "Seclusion and restraint – One Hour Face to Face Evaluation Form", showed that there is no documentation that an interpreter was present for the evaluation regarding patient release from the seclusion room. 7. During an interview on 9/18/19 at 10:45 AM, Staff M, RN, stated "the patient [Patient #2] was given a B52 [an involuntary medication administered through injection that contains benedryl, haldol, and ativan] without an interpreter present, there were hand written notes they would put up in the seclusion room asking the patient if he was ready to calm down". 8. Document review of the facility's policies and procedures showed that they only referenced WAC 246-341-0420, but did not specifically reference WAC 246-34-0420(5)(a). The facility provided policy and procedures titled "Patient Bill of Rights", dated 09/2018; "Program Overview / Scope of Care – Inpatient", dated 07/2019; and "Completing and Submitting reports", dated 10/2018. Review of these policies and procedures showed that they do not address the availability of interpreter services for individuals that have sensory disabilities.	
WAC 246-341-0620(1)(e) Each facility licensed by the department to provide any behavioral health services is responsible for an individual's service plan as follows (1) the individual service plan must: (e) Contain measurable goals or objectives, or both, and interventions.	Based on record review, the facility failed to document measurable goals or objectives, and interventions for 3 of 10 patient clinical records reviewed (Patient #2, #3, and #8). Failure to document measurable goals or objectives, and interventions, can result in poor Patient care. Findings included: 1. The clinical record for Patient #2 showed that the Individual Service Plan does not contain measurable goals or	

	interventions based on the following: a. The "Initial Treatment Plan" (ISP) for Patient #2, dated 07/26/19, states the patients long term goal is "unable to answer". There are no other goals or further explanation for the patient's inability to list a goal, on the ISP for Patient #2. b. The ISP contained incomplete interventions. The ISP showed that "staff will provide a 1 hour DBT group, 2 times a day, to help patient with: ". [no information was written on form after this statement] 2. Review of clinical record for Patient #3 showed that the form, Initial Treatment Plan [ISP], dated 08/26/19, states the patients long term goal is "be safe and not killing myself". There is no other goals on the initial treatment plan. 3. Review of the clinical record for Patient #8 showed that the Individual Service Plan does not contain measurable goals or interventions based on the following: a. Clinical record for Patient #8, showed that the "Initial Individual Services Plan", dated 8/20/19, states the patients long term goal is "to be sober and happy". There is no other goals on the treatment plan. b. Clinical record for Patient #8 showed that the "Initial Individual Service Plan", dated 8/20/19, contained incomplete interventions. The ISP showed that "staff will provide a 1 hour DBT group, 2 times a day, to help patient with: ". [no information was written on form after this statement]	
WAC 246-341-0620(1)(f) Each facility licensed by the department to provide any behavioral health services is responsible for an individual's service plan as follows (1) the individual service plan must: (f) be updated to address applicable changes in identified needs and achievement of goals.	Based on record review and interview, the facility failed to ensure the individual service plan (ISP) was reviewed and updated to reflect changes in the patient's treatment needs and achievement of goals for 3 of 10 patient clinical records reviewed (Patient #3, #8, and #9), as the patient progressed through treatment.	

	Failure to ensure the individual service plan was reviewed and updated to reflect any changes in the patient's treatment needs can result in inadequate treatment and poor patient outcomes. Findings Included: 1. Review of the clinical record for Patient #3 showed that the individual services plan was not updated to reflect the individual treatment needs and achievement of goals, based on the following: a. The "Treatment Planning and Problem Sheet", dated 8/26/19, lists the Patient problem statement as "patient lacks life skills and coping skills to manage depression and psychosis with continued using of meth". The short term goals and interventions related to this problem were not updated or modified to address a change in treatment needs. The patient clinical record showed that physical health issues and behaviors related to her mental illness became more severe while the Patient was in treatment, and she became unable to attend group sessions. b. The "Initial Treatment Plan", dated 8/26/19, lists the intervention as "staff will provide a 1 hour DBT group, 2 times a day, to help patient with: suicidal ideation / depression psychosis". The intervention was not updated to reflect the patient's individual treatment needs as her physical health issues and behaviors related to her mental illness became more severe, and she became unable to attend DBT groups. 2. Review of the clinical record for patient #8 showed that the individual service plan was not updated to reflect the individual treatment needs of the Patient based on the following: a. Review of the ISP, dated 8/20/19, showed that the ISP contained incomplete information related to Patient #8's one	

	hour DBT group. The ISP showed that "staff will provide a 1 hour DBT group, 2 times a day, to help patient with: ". [no information was written on form after this statement] b. Review of group notes showed that Patient #8 attended a total of 3 groups over 6 days, which did reflect the assigned intervention of attending 12 groups during this timeframe. c. Review of the ISP showed that there is no documentation that the ISP was updated to determine an alternate treatment, or different treatment modality to reflect the individual treatment needs of Patient #8, who was not attending group sessions as assigned. 3. Review of the clinical record for patient #9 showed that the individual services plan was not updated to reflect the individual treatment needs of the Patient based on the following: a. Review of the "Level of Care / Psychological Assessment", dated 9/6/19, states "Patient is recommended to attend all Psychoeducational groups 2 X per day while in detox..." b. Review of group records showed that Patient #9 attended 1 group over 7 days. c. Review of the ISP was not updated to determine a different course of treatment to meet the Patients individual treatment needs for Patient #9, who was not attending groups as assigned. 4. During an interview on 09/25/19 at 3:15 PM, Staff G, Director of Clinical Services, stated, "We have had issues with treatment plans....there is stock language used, it can be easy to lose patient centered focus. I am constantly training, this is a culture change for the staff, and this is a muscle that they need to work a bit more. There was quality around treatment planning that wasn't met under the past supervisor. I have been here for 3 months."	

246-341-1126(9)(a) In addition to meeting the facility licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WC 246-341-1118 through 246-341-1132, and inpatient facility must implement all of the following administrative requirements (9) the treatment plan must contain documentation of: (a) diagnostic and therapeutic services prescribed by attending clinical staff	Based on record review and interview, the facility failed to document in the treatment plan diagnostic and therapeutic services prescribed by attending clinical staff, for 3 of 10 patient clinical records reviewed [Patient #3, #5 and #8]. Failure to document in the treatment plan diagnostic and therapeutic services prescribed by attending clinical staff can result in a lack of documentation that prescribed treatment occurred. Findings included: 1. Review of the clinical records for Patient #3, showed that the treatment plan did not contain documentation of diagnostic and therapeutic services prescribed by attending clinical staff based on the following: a. The "Level of Care / Psychological Assessment", dated 9/6/19, states "Patient is recommended to develop a solid relapse prevention and safety plan [a written plan the Patient can reference in a time of crisis] prior to discharge date...". b. The "Safety Plan" for Patient #3, dated 9/16/19, does not contain information to help Patient stay safe based on the following: (1). The "Safety Plan" showed that Patient #3 is unable to list anything he can do to take his mind off his problems "because all he has known is drug use". (2). The "Safety Plan" showed that Patient #3 lists no one that he can ask for help. The Safety Plan showed that the Patient feels little interest or pleasure in doing things, and feels down or hopeless nearly every day. (3). The "Safety Plan" showed that Patient #3 has no therapist or doctor that the Patient can call if needed.	

	2. Review of the clinical records for Patient #5, showed that the treatment plan did not contain documentation of diagnostic and therapeutic services prescribed by attending clinical staff based on the following: a. Review of "Multidisciplinary Treatment Plan", dated 4/29/19, showed that the treatment plan for discharge included the Patient #5 being "encouraged to step down to PHP [mental health day treatment program affiliated with the facility] and then to outpatient services. Patient will have a safety plan in place prior to discharge". b. "Progress Note" for Patient #5, dated 05/04/19, states "Patient and partner complained about the therapist clinician set him up with at Western Psychological [an outpatient program] on Monday and request for someone else... Patient asked clinician if he is still able to enroll for the PHP program. Clinician informed patient to come back on Monday to sign up for PHP because it's the weekend, Clinician is unable to send in paperwork to PHP but clinician will inform them that the patient was interested in going through the PHP program". 3. During an interview on 9/25/19 at 3:15PM, Staff G, Director of clinical Services, stated that the discharge planning and therapy were siloed in the past. There was a lack of communication regarding discharge planning. 4. Record review for Patient #8, showed that the treatment plan did not contain documentation of diagnostic and therapeutic services prescribed by attending clinical staff based on the following: a. Review of "Treatment Planning Problem Sheet", dated 8/20/19 showed that an intervention for Patient #8 would be attending Cognitive Behavioral Therapy Group two times a day for one hour to help patient with managing depression, suicidal Ideation, and Paranoia.	

	b. Review of group notes showed that Patient #8 attended a total of 3 groups over 6 days, the Patient attended two of those groups on the date of discharge.	
246-341-1126(9)(e) In addition to meeting the facility licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WC 246-341-1118 through 246-341-1132, and inpatient facility must implement all of the following administrative requirements (9) e treatment plan must contain documentation of: (e) Documentation of the course of treatment.	Based on record review and interview, the facility failed to document the course of treatment throughout the patients' treatment at the facility, for 3 of 10 patient clinical records reviewed [Patient #1, #3, and #9]. Failure to document the course of treatment throughout the patients' treatment at the facility can result in poor patient care and poor patient outcomes. Findings Included: 1. Review of the clinical record for Patient #1 showed that the course of treatment was not documented in the record as there is incongruent documentation regarding the patients' mental health status based on the following: a. Clinical records showed that Patient #1 assaulted multiple staff on 03/13/19, and a Medical Provider approved the administration of involuntary medication through injection on 03/13/19. The "Inpatient / PHP Discharge Summary", dated 03/14/19, shows "on 3.13.2019 morning the patient was agitated and her behavior was out of controlled *[sic]*. She demanded to go out to smoke a cigarette but it was not time for the unit to go out to smoke. Patient was threaten *[sic]* staffs members and demand to be discharged or she will hurt others. Unable to verbally de-escelated *[sic]* the patient the patient was given PRN IM meds [an involuntary medication given through injection] with the assistant *[sic]* of staffs *[sic]* members for her safety and the safety of others". b. Progress notes indicate mental health treatment staff requested that Patient #1 receive an evaluation from a Designated Crisis Responder (DCR) on 03/13/19 to evaluate the need for an involuntary hold in inpatient treatment.	

	There is no documentation in the treatment record that an evaluation by a DCR was completed. c. The "Inpatient / PHP Discharge Summary", dated 03/14/19 showed that Patient #1 was discharged on 03/14/19 against medical advice. The form states "...Patient was upset this morning because she didn't get a cigarette and wanted to be discharged AMA and was no longer considered to be suicidal / homicidal / unsafe outside of a structured setting. No imminent safety concerns..." The form lists the condition on discharge as stable. d. Review of progress note, dated 03/14/19, showed that Patient #1's Mom phoned the facility after the patient was discharged to report that the family had directly contacted the DCR. A DCR was scheduled to meet with the Patient at the Mom's residence in order to complete an evaluation for involuntary treatment. 2. Review of the clinical record for Patient #3 showed that the course of treatment was not documented in the record based on the following: a. The "Treatment Planning Problem Sheet", dated 08/26/19, states "Patient will complete a safety plan before discharge to address the following symptoms / risk factors: depression, psychosis, and suicide ideation". b. The "Safety Plan" [a written plan the patient can reference in a time of crisis], dated 08/28/19, does not contain information to help Patient #3 stay safe, and does not address depression, psychosis, and SI based on the following: (1). The "Safety Plan" showed that Patient #3 is unable to list anything she can do to take her mind off her problems. (2). The "Safety Plan" showed Patient #3 lists no one that she can ask for help.	

	(3). The "Safety Plan" showed that Patient #3 has no therapist or doctor that the patient can call if needed. c. Review of "Treatment Planning Problem Sheet", dated 08/12/19, showed an assigned treatment intervention was for the Medical Provider to meet daily with Patient #3 to assess medication effects, including side effects and effectiveness. d. Review of the "Psychiatric Inpatient Progress Note", dated 07/31/19, for Patient #3 showed that the form is signed by a Provider and dated, but does not have any content completed. All fields, such as Assessment of Progress and Response to Treatment, are blank. There is no other documentation showing a Provider met with the patient on 07/31/19. e. Review of "Multidisciplinary Treatment Plan", dated 07/27/19, showed that the discharge plan was for Patient #3 to report a reduction in psychotic symptoms and have patient set up an appointment with a therapist for aftercare. f. Review of the "Discharge Communication for IP" [In Patient] Form, dated 08/12/19, showed that "N/A" is written on the form, and there is no disposition code or reason code selected. 3. Review of the clinical record for Patient #9 showed that the course of treatment was not documented in the record based on the following: a. The "Level of Care / Psychological Assessment", dated 9/6/19, states "Patient is recommended to attend all Psychoeducational groups 2 X per day while in detox..." b. Review of group records showed that Patient #9 attended 1 group over 7 days. c. The Level of Care / Psychological Assessment, dated	

	9/6/19, states "Patient is recommended to develop a solid relapse prevention and safety plan [a written plan the Patient can reference in a time of crisis] prior to discharge date..." d. The "Safety Plan" for Patient #9, dated 9/16/19, does not contain information to help the Patient stay safe based on the following: (1). The "Safety Plan" showed that Patient #9 is unable to list anything he can do to take his mind off his problems "because all he has known is drug use". (2). The "Safety Plan" showed Patient #9 lists no one that he can ask for help. The Safety Plan showed that the Patient feels little interest or pleasure in doing things, and feels down or hopeless nearly every day. (3). The "Safety Plan" showed that Patient #9 has no therapist or doctor that the Patient can call if needed. (4). The "Safety Plan" for Patient #9, dated 9/16/19, showed a transcribed note by a nurse from a statement from Dr. Simas that states "Pt has gained maximum benefit from inpatient hospitalization, patient denying any active suicidal ideation".	
/AC 246-341-0640(15)(a)(i) Each facility licensed by the department to provide any behavioral health service is responsible for an individual's clinical record content. The clinical record must include (a) Discharge information for an individual who did not leave without notice, completed within seven working days of the individual's discharge, including: (i) continuing care plan.	Based on record review, the facility failed to document discharge information for an individual who did not leave without notice, completed within seven working days of the individuals discharge, including a continuing care plan, for 1 of 10 Patients reviewed (Patient #3). Failure to document discharge information for a patient who did not leave without notice, completed within seven working days of the patients discharge can result in poor patient care. Findings included: 1. Review of Patient #3's clinical record showed that the	

	discharge continuing care plan was completed on 8/29/19 when the patient was discharged to the hospital due to medical issues. The Patient returned to the facility on 09/02/19, and was discharged back to the hospital again on 09/02/19 due to medical issues. There is no documentation of a discharge continuing care plan for the 09/02/19 discharge.	
WAC 246-41-1100(3)(a) Substance used disorder withdrawal management services are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, in accordance with ASAM criteria. (3) A facility must: (a) Use ASAM criteria for admission, continued services, and discharge planning and decisions.	Based on record review and interview, the facility failed to use ASAM criteria for admission, continued services, and discharge planning and decisions for 1 of 2 withdrawal management Patients reviewed (Patient #4). Failure to use ASAM criteria for admission, continued services, and discharge planning and decisions can result in poor treatment outcomes. Findings Included: 1. During an interview on 09/24/19 at 11:45 AM, Staff C, title, stated that the facility will transition a Patient from withdrawal management services to mental health services upon a Doctors' Order, when staff identify the Patient as having high mental health needs. There is a transfer form that is completed, not a discharge summary. Staff C stated "I don't know how the ASAM piece is followed up, once they leave my side [substance use disorder treatment] I have no idea what happens next. 2. Review of clinical record for Patient #4 showed that ASAM criteria was not used for continued services and discharge planning based on the following: a. Records showed that Patient #4 was transferred from the withdrawal management unit [substance use disorder services] to the mental health unit on 09/02/19, after the patient expressed having suicidal ideation. There is no documentation that a discharge summary, including recommended ASAM Level of Care, was completed when the	

	patient discharged from the withdrawal management unit to the mental health unit. b. Review of records showed that Patient #4 remained in inpatient mental health treatment, with no continued substance use disorder treatment based on ASAM provided by a Chemical Dependency Professional, from 09/02/19 to 9/20/19. An "Inpatient Progress Note", dated 09/20/19, states, "The patient is a 48 year old male with a working diagnosis of alcohol use disorder and polysubstance use disorder. The patient appears to be tolerating his current medication well, and has no complaints of side effects. At this point, the patient is waiting for a bed in a residential substance abuse treatment facility". 3. During an interview on 9/24/19 at 1:00 PM, Staff D, Mental Health Therapist, stated "We don't do substance use disorder work if a Patient is in the mental health unit. The substance use disorder piece comes in as aftercare [after discharge from inpatient mental health services]. We want to follow CFR 42 rules and don't want to out the Patient [for having substance use disorder issues] on the mental health unit".	

Behavioral Health Facility
Telephone Contact Numbers

Management and Other Resources

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Introduction
We require that you submit a plan of correction for each deficiency listed on the investigation report form. Your plan of correction must be Submitted to DOH within fourteen calendar days of receipt of the list of deficiencies.

You are required to respond to the Investigation Report with Noted Deficiencies by submitting a plan of correction (POC). Be sure to refer to the deficiency number. If you include exhibits, identify them and refer to them as such in your POC.

Descriptive Content
Your plan of correction must provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and provide information that ensures the intent of the regulation is met.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

Simply stating that a deficiency has been "corrected" is not acceptable. If a deficiency has already been corrected, the plan of correction must include the following:

- How the deficiency was corrected,
- The completion date (date the correction was accomplished),
- How the plan of correction will prevent possible recurrence of the deficiency.

ompletion Dates
The POC must include a completion date that is realistic and coinciding with the amount of time your facility will need to correct the deficiency. Direct care issues must be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies that require bids, remodeling, replacement of equipment, etc., may need more time to accomplish correction; the target completion date, however, should be within a reasonable and mutually agreeable time-frame.

Continued Monitoring
Each plan of correction must indicate the appropriate person, either by position or title, who will be responsible for monitoring the correction of the deficiency to prevent recurrence.

Checklist:

- Before submitting your plan of correction, please use the checklist below to prevent delays.
- Have you provided a plan of correction for each deficiency listed?
- Does each plan of correction show a completion date of when the deficiency will be corrected?
- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated what staff position will monitor the correction of each deficiency?
- If you included any attachments, have they been identified with the corresponding deficiency number or identified with the page number to which they are associated?

Your plan of correction will be returned to you for proper completion if not filled out according to these guidelines.

Note: Failure to submit an acceptable plan of correction may result in enforcement action.

Approval of POC

Your submitted POC will be reviewed for adequacy by DOH. If your POC does not adequately address the deficiencies in your report you will be sent a letter detailing why your POC was not accepted.

Questions?

Please review the cited regulation first. If you need clarification, or have questions about deficiencies you must contact the investigator who conducted the onsite investigation, or you may contact the supervisor.

tab #	Standard Cited	Action Plan	Process (Education/Training)	Monitoring and Tracking	Responsible Person	Date
1	WAC 246-341-0410(2)(c) The administrator must: (c) Employ sufficient qualified personnel to provide adequate treatment services and facility security.	Director of Clinical Services is hiring more staff to adequately provide mental health therapy treatment. Interviews are being conducted to fill any open positions. Director of Clinical Services will report to Governing Board compliance with approved hospital staffing model. Therapy staff will provide groups and will be provided by trained staff.	Director of Clinical Services will meet with therapists during the week for next 4 months to ensure they are able to provide 100% of groups for the next day per regulations. If staffing is inadequate for the next day, Director of Clinical services will call per-diem staff to provide groups or the Director of Clinical Services can provide groups. Director of Clincial Services will meet with HR montly to review any open positions.	Provision of care and staffing model will be reviewed annually.	Rebecca Brandley; Director of Clinical Services	06-Nov
2	WAC 246-341-1126(1)(e) In addition to meeting the facility licensure, certification, administration, personnel, and clinical requirement in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WAC 246-341-1118 throug	1. Procedure in place and will be reviewed which addresses staffing for mental health professionals and substance use staffing. 2. CPI has been moved to 2 day trining to be a total of 12-14 hours, which will include de-escalation techniques and physical intervention skills. CPI refresher courses are conducted every 6 weeks and are mandatory for nursing staff until staff feel comfortable with ability to preform CPI.	1. Procedure is written and will staff will be educated on staffing model. 2. Orientation has been modified to include 2 days of CPI training for total of 12-14 hours. The DON has implented CPI refresher courses 6 week after initial CPI course. A Code 100 committee was created and meets monthy. The Code 100 committee implemented "Code 100 drills" which take place at least 1x a month for the day shift and 1x a month for the night shift. These drill are "life like drills" that happen off the unit (not in front of patients) but with staff members participating and acting as patients.	1. DCS will meet with clinical staff and SUD professionals daily to ensure adaquate staffing is available for the next day. 2. HR to audit and monitor attendence of initial CPI course and refresher course for the next 4 months. HR to report out in Quality Committee copliance with CPI. Director of Quality meets with the Code 100 Committee monthly to go over CPI drills.	Heather Hernandez; Director of Quality	06-Nov
3	WAC 246-341-0420(5)(a) Each facility licensed by the department to provide any behavioral health service must develop, implement, and maintain administrative policies and procedures to meet the minimum requirements of this chapter. The policies and procedures must demonstrate the following, as applicable: (5) Interpreter services for individuals with limited-English proficiency (LEP) and individuals who have sensory disabilities. Documentation that demonstrates the facility's ability to provide or coordinate services for individuals with LEP and individuals who have sensor disabilities. This means: (a) Certified interpreters or other interpreter services must be available for individuals with limited-English- Speaking proficiency and individuals who have sensory disabilities.	Policy # 5182826 Communication with Persons with Limited English Proficiency (LEP) and Sensory Disabilities will be updated to include more indepth procedure regarding how staff will contact and use certifed interpreters for patients with sensory disabilites. Each unit has access to Google Chrome book for immidate interpretive services needs which includes those services for some sensory disabilites. Facility will secure an in person interpretive services through facilities contracted services promptly. When an interpreter or Chrome Book is used it will be documented as such, ie; "patient participated in group via interpreter."	Policy will be reviewed and approved, once approved staff and leadership will be educated on new polilcy regarding staffing. Appropriate clinical, nurses, PCAs, and assessment staff will be educated on how to use Google Chrome books for accessing language line app and will be educated on how to contact the facilities in person contracted interpreters. Education of clinical staff and nursing staff regarding documentation of using interpreter services.	100% of patients who require interpreters will be audited by Director of Quality. The audit will include when the patient arrived, when the interpreter was contacted, how long the interpreter was used each day. The audit will be conducted for the next 4 months.	Heather Hernandez, Director of Quality	06-Nov
4	WAC 246-341-0620(1)(e) Each facility licensed by the department to provide any behavioral health services is responsible for an individual's service plan as follows (1) the individual service plan must: (e) Contain measurable goals or objectives, or both,	Treatment plans will be complete and contain measureable goals and interventions.	DCS provided education to clinical staff and SUD staff on developing meaningful and person centered measurable goals, objectives, and interventions for treatment plans.	Director of Clinical Services will audit treatment plans of 20 charts daily next 4 months to ensure the content of the treatment plans are individualized with measurable goals and intervention. DCS will report out compliance during Quality Committee	Rebecca Brandley; Director of Clinical Services	06-Nov
5	WAC 246-341-0620(1)(f) Each facility licensed by the department to provide any behavioral health services is responsible for an individual's service plan as follows (1) the individual service plan must: (f) be updated to address applicable changes in iden	Treatment plans will be complete, indivdualized and reflect the treatment needs and progress and achievement of goals through treatment	DCS provided education to clinical staff and SUD professionalson ensuring treatment plans document the progression of goals obtained. DCS also to provide education to clinical staff and SUD staff on documenting when a patient does not meet goals and/or a new problem presents.	Director of Clinical Services will audit treatment plans of 20 charts daily for next 4 months to ensure appropriate follow through and documentation compliant it met. DCS will report out compliance during Quality Committee	Rebecca Brandley; Director of Clinical Services	06-Nov

6	246-341-1126(9)(a) In addition to meeting the licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WC 246-341-1118 through 246-341-113	Treatment plans, Safety Plans and clinical documention will be complete and document diagnostic and therapeutic services prescribed by attending clinicial staff.	DCS provided education to clinical staff and SUD professionals on ensuring all clinical documentation is complete and documents diagnostic and therapeutic services provided and prescribed. Documentation must also include when a patient does not participate in therapeutic services (such as not attending groups) and show what follow up was provided.	Director of Clinical Services will audit treatment plans of 20 charts daily for next 4 months to ensure documentation climpliance is met. DCS will report out compliance during Quality Committee	Rebecca Brandley; Director of Clinical Services	06-Nov
7	246-341-1126(9)(e) In addition to meeting the facility licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WC 246-341-1118 through 24	Treatment plans will be complete and show how the patient has progressed through treatment and will address if the patient is not participating in treatment and what follow up was provided. Desgnated Crisis Responders or floor staff will write a progress note regarding the outcome of any Involuntary Treatment Assessment that was completed.	DCS provided education to clinical staff and SUD professionals on ensuring treatment plans document the progression of goals obtained. DCS also to provide education to clinical staff and SUD staff on documenting when a patient does not progress thought treatment and/or a new problem presents. DON will educated charge nurses and house supervisor on documenting outcomes of Designated Crisis Responders(DCR) Involuntary Treatment Act Assessments. DCR's will complete a form created by DCRs which will detail the outcome of ITA assessment.	Director of Clinical Services will audit treatment plans of 20 charts daily for next 4 months to ensure appropriate follow through and documentation compliance it met. DCS will report out compliance during Quality Committee	Rebecca Brandley; Director of Clinical Services	06-Nov
8	WAC 246-341-0640(15)(a)(i) Each facility licensed by the department to provide any behavioral health service is responsible for an individual's clinical record content. The clinical record must include (a) Discharge information for an individual who did n	Discharge Summaries will be completed within 7 days.	Providers received education on discharge summary deadlines MEC on 10/31. Manager of HIM will monitor dishcarge summaries daily. If a discharge summary is missing HIM manager will contact the provider to ensure they will complete and provide a discharge summary.	Manager of HIM will audit 100% of discharge summaries daily to ensure they are done in a timely manner. Manager of HIM will report out in Flash daily and during Quality Committee montly and quarterly at MEC and Board Report	Kim Howard, Manager HIM	31-Oct
9	WAC 246-41-1100(3)(a) Substance used disorder withdrawal management services are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, in accordance with ASAM criteria. (3) A facility	SUD professionals will continue to follow patients as they transfer to the mental wellness unit so they can assist with discharge planning process. SUD professionals will ensure the ASAM criteria is used during the progession of treatment and used to help aide in discharge planning.	DCS will educate the SUD professionals on process and procedures of continuing treatment with patients transferred to the mental wellness unit from SUD unit. DCS will educate SUD professionals on using ASAM criteria to assist mental wellness clinicians with dischage planning.	DCS will audit 100% of patients who transfer from SUD unit to mental wellness unit to ensure ASAM criteria is being used to for treatment planning, and discharge planning. Any patients that transfer will be documented on a "Change of Status form" and will be discussed at treatment team meeting daily.	Rebecca Brandley; Director of Clinical Services	06-Nov

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

December 3, 2019

Rainier Springs
2805 NE 129th Street
Vancouver, WA 98686-3324

Re: Case Number: 2019-10497, 2019-10764, 2019-10936, 2019-11556, 2019-12018
License Number: BHA.FS.60888597
Acceptable Plan of Correction
Date of Survey: October 1, 2019

Dear Administrator:

This letter is to inform you that after careful review of the Plan of Correction (POC) you submitted for the investigation recently conducted at your hospital, the Department has determined that the POC is acceptable. You stated in your plan that you will implement corrective actions by the specified timeline. By this, the Department is accepting your Plan of Correction as your confirmation of compliance.

Based on the scope and severity of the deficiencies listed in your statement of deficiency report, the Department will conduct an unannounced follow-up compliance visit to verify that all deficiencies have been corrected.

The Department reserves the right to pursue enforcement action for any repeat and/or uncorrected deficiencies based on applicable statute and rules.

Please contact me at julie.marshall@doh.wa.gov if you have questions regarding the investigation.

Sincerely,

JMarshall

Julie Marshall, Behavioral Health Investigator
Washington State Department of Health
HSQA/Office of Health Systems Oversight