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 _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
L1160	Continued From page 2 for involuntarily treatment on 07/09/21 for hallucinations, paranoia and psychosis. The review showed the following: a. A seclusion/restraint order was written on 07/11/21 at 9:00 AM. The order showed that Patient #1010 was placed in seclusion for agitation and harm to self. The patient was released from seclusion on 07/11/21 at 9:45 AM. b. A second order for seclusion/restraint was placed for Patient #1010 on 07/11/21 at 3:15 PM. The order showed that Patient #1010 was placed in mechanical restraints for physically threatening behavior to others and self-harm. Patient #1010 was released from mechanical restraints on 07/11/21 at 3:45 PM. c. The surveyor could find no evidence that the master treatment plan had been updated with the additional problem of seclusion after the patient was placed in seclusion on 07/11/21 at 9:00 AM. Furthermore, the review showed no evidence that the treatment plan had been updated to include measures to prevent recurrence. 3. On 10/06/21 at 3:00 PM, Surveyor #10 interviewed the Program Director (Staff #1010) regarding the missing treatment plan and required update to master problem list. Staff #1010 verified and confirmed the above findings pertaining to the missing documentation.	L1160		
L1290	322-200.3K RECORDS-NURSE SERVICES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into	L1290		

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L1290	Continued From page 3 the clinical record for each period a patient receives inpatient or outpatient services: (k) Nursing services; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's Internal Transfer policy and procedure for documentation in 1 of 1 record reviewed. (Patient #1011) Failure to follow established policies and procedures places patients at risk of delayed treatment and physical and psychological harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Transfer Internal," policy number POC 100.89, last reviewed 04/21, showed that in order to provide a coordinated method of transferring patients within the hospital, the charge nurse is to document all pertinent information in clinical notes. 1. On 10/05/21 at approximately 3:00 PM while inspecting the medication room of the Dual Diagnosis Unit, Surveyor #10 and a Program Director (Staff #1010) observed Patient #1011 becoming agitated. Patient #1011 was transferred to a higher level of care within the hospital on 10/05/21 at approximately 3:15 PM. 3. Document review of the Daily Nursing note dated 10/05/21 showed that: a. The patient was on unit restriction and was to	L1290		

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L1290	Continued From page 4 be observed every 15-minutes with special precautions for self-harm and assault/homicidal behavior. b. On 10/05/21 at 3:18 PM, the patient became agitated when the PRN (as needed) dose of Ativan (a prescription drug for anxiety) was decreased. The note also showed the patient was delusional, paranoid, oppositional, threatening, impulsive, talking loudly, screaming, and agitated. c. On 10/05/21 at 3:20 PM, the patient became impulsive, unpredictable, slamming into doors while demanding to leave. The record showed no self-harm attempts or falls. d. The surveyor found no evidence in the medical record that pertinent information was documented after the internal transfer of the patient to a higher level of care by the receiving unit. e. On 10/06/21 at 5:10 AM a nursing note showed the patient was in bed sleeping the entire shift, did not come out for medications or snack, and that medications were taken to the patient in her room. The note also showed that the patient denied any suicidal ideation or self-harm thoughts. 4. On 10/06/21 at 9:30 AM, Surveyor #10 interviewed the Registered Nurse (Staff # 1011) caring for Patient #1011 after the internal transfer. Staff #1011 stated that she was on a break when the patient was transferred and did not document the patients condition or behavior on the patient after her arrival to the unit. 5. On 10/06/21 at 9:30 AM, Surveyor #10 and the Program Director (Staff #1010) reviewed the patient's medical record. Staff #1010 verified and	L1290		

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L1290	Continued From page 5 confirmed there was no pertinent documentation about the patient's condition after the internal transfer of Patient #1011.	L1290		
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 observation, interview, document review, and review of the hospital's polices and procedures, the hospital failed to ensure staff members followed its policy for safe medication administration. Failure to follow safe medication administration standards risks medication errors and patient harm. Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration," policy number MM 100.25, last reviewed 04/21, showed that the nurse will scan each mediation that has a barcode. All ordered medications will be administered after verification. Document review of the hospital policy and procedure titled, "Patient Identification," policy	L1375		

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L1375	Continued From page 6 number POC 100.49, last reviewed 04/21, showed that before medication administration, staff will verify correct patient identity. Barcode scanning is the preferred method of identification. If a patient refuses to wear an armband, the patient photo, name and date of birth will be used to identify the patient. 2. On 10/05/21 at 9:30 AM, Surveyor #3, Surveyor #10, and the Program Manager (Staff #301) inspected the medication room on the Intensive Care Unit and observed medication administration for several patients. Surveyor #3 observed three small clear plastic cups with several medications in in their original packaging. The medication cups were observed lying on the unit patient identification photograph page by Patient #301, #302, and #303's photographs, respectively. Surveyor #3 asked the nurse (Staff #302) who was passing medications for the unit why there were three cups of medications on the counter. Staff #302 stated that those patients frequently did not get up during normal medication times and would be given once they were up and out in the day room. Surveyor #3 then asked Staff #302 to access the medication administration record (MAR) for Patients #301, #302 and #303. The MAR showed that the medications ordered for each of these 3 patients were documented showing that the medication had been scanned and recorded as administered between the 7:53 and 7:54 AM on 10/05/21. Staff #302 stated that she would go back to the MAR and edited the administration time when the medication was actually administered. 3. At the time of the observation, Surveyor #3 interviewed the the Program Manager (#301) who	L1375		

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L1375	Continued From page 7 confirmed that the staff member had not followed the hospital policy for medication administration. 4. On 10/06/21 at 8:50 AM, Surveyor #3 and the Program Manager (Staff #301) toured the Women's Unit and observed a medication administration. Surveyor #3 observed a Registered Nurse (Staff #303) administer medications to a patient (Patient #304) located in a hallway near the patient rooms. Staff #303 called the patient by their first name and handed her a small plastic cup containing three medications. The Program Manager (Staff #301) then prompted Staff #303 to ask the patient to state their full name and date of birth. 5. Immediately following the observation, Surveyor #3 interviewed the Program Manager (Staff #301) about medication administration when barcode scanning is not possible. Staff #301 stated that Staff #303 should have asked the patient their full name and date of birth and compared it with the unit patient identification photograph page. Staff #301 confirmed that the nurse had not followed the hospital policy for administering medications.	L1375		

State of Washington

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S 000	Initial Comments This report is the result of an unannounced Fire and Life Safety survey conducted at Smokey Point Behavioral Hospital in Marysville, Washington on 10/7/2021 by representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health survey team. During the physical tour of the facility I was accompanied by the Facilities Director who witnessed any deficiency noted during this survey. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. This facility is located in a two story structure without a basement, of type 2-A construction. The building is protected by a Type 13 sprinkler system throughout. The building has an Automatic / Manual Fire Alarm System with corridor smoke detection. The facility is licensed for 115 patients and the current census is 83. The facility is in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Brendan Magee Deputy State Fire Marshal 38402 The surveyor was from: Washington State Patrol Office of the State Fire Marshal Fire Protection Bureau 2803 156th Ave SE Bellevue, WA 98007 Telephone: (360) 481-3933	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eugene Arkhi | TITLE: CEO | (X6) DATE: 10/22/21

State of Washington

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Plan of Correction Received
22 OCT 21

Plan of Correction Approved
25 OCT 21
RN, MN, MH
21227

L1160 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that staff members followed the hospital's seclusion policy and procedure for documentation.

Procedure/process for implementing the plan of correction:
The CNO, Medical Director & DCS/designees will provide written education to all Nursing staff, psychiatric providers and clinical services staff regarding seclusion documentation. Education will include, but not be limited to:

- Reviewing & amending the treatment plan follow the first episode of seclusion to include measures to prevent recurrence.
- Adding seclusion to the Master Treatment Plan

Monitoring and Tracking procedures to ensure the plan of correction is effective:
The CNO & DCS/designees will audit 100% of seclusion charts weekly for addition to the MTP for compliance and re-educate staff as needed. Audits will continue until 100% compliance is noted for 3 consecutive months.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The CNO & DCS will report compliance weekly to CEO.
- Data will be provided to PI department weekly for logging & analysis
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee
- Quarterly Report to Governing Board

Individual Responsible:
CNO, Medical Director & DCS

Date Completed:

11/5/21

L1290 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that staff members followed the hospital's Internal Transfer policy and procedure for documentation.

Procedure/process for implementing the plan of correction:

- A communication tool has been developed to notify clinical leadership of internal patient transfers.
- The CNO and DCS/designees will provide written education to nursing staff, psychiatric providers, and clinical services staff regarding policy titled POC 100.89 Transfers Internal. Education will include, but is not limited to:
    - Documenting all pertinent information in clinical notes prior to transfer to another unit or program, including significant incidents or change in condition.
    - Use of the Internal Transfer Communication Tool

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- CNO & DCS/designee will audit 100% of internal transfer charts weekly for compliance with Internal Transfer policy. Audits will continue until 100% compliance is noted for 3 consecutive months.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- CNO & DCS will report compliance weekly to CEO & Governing Board.
- Data will be provided to PI department weekly for logging and analysis
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee.
- Quarterly report to Governing Board

Individual Responsible:
CNO & DCS

Date Completed:

11/5/21

L1375 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that staff members followed its policy for safe medication administration.

Procedure/process for implementing the plan of correction:

- The CNO designees will provide written education to nursing staff regarding policies titled MM 100.25 Medication Administration and POC 100.49 Patient Identification. Education will include, but is not limited to:
    - Scanning each medication at the time of administration, without pre-scanning
    - Properly identifying each patient with two identifiers prior to medication administration using barcode scanning and/or patient photo, name and date of birth.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- CNO/designees will audit at least 5 medication administrations per week. Audits will continue until 100% compliance is noted for 3 consecutive months.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- CNO will report compliance weekly to CEO & Governing Board.
- Data will be provided to PI department weekly for logging and analysis
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee.
- Quarterly report to Governing Board

Individual Responsible:
CNO

Date Completed:

11/5/21

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

January 4, 2022

Ms. Kellie Reilly
Director of PI, Risk, and Patient Advocate
Smokey Point Behavioral Hospital
3955 156th Street NE
Marysville, WA 98271

Dear Ms. Reilly,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Smokey Point Behavioral Hospital on October 5-7, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on October 25, 2021.

Hospital staff members sent a Progress Report dated January 3, 2022 that indicates all deficiencies have been corrected. The Department of Health accepts Smokey Point Behavioral Hospital's attestation to be in compliance with Chapter 246-322 WAC.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Paul Kondrat

Paul Kondrat, MHA, MN, RN
Survey Team Leader