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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) COMPLETION DATE
{E 000}	Initial Comments . MEDICARE COMPLAINT INVESTIGATION FOLLOW-UP VISIT (Intake # 87038) The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482 for hospitals, conducted this health and safety investigation. Onsite dates: 04/02/19 to 04/05/19 During the follow-up visit, surveyors also investigated allegations related to the following Medicare complaint intake numbers: 88448, 88994, 89234, and 89238. The survey was conducted by: Surveyors #3 Surveyor #5 Surveyor #9 Surveyor #11 During the course of this follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the hospital's systemic failure to ensure allergies were verified prior to preparation and administration of medications. Surveyors declared an IMMEDIATE JEOPARDY on 04/02/19 at 5:20 PM. The hospital initiated corrective action and removal of the state of IMMEDIATE JEOPARDY was verified on 04/05/19 at 1:20 PM by the DOH survey team.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{E 000}	Continued From page 1 DOH staff determined that the facility remained NOT IN COMPLIANCE with the following Medicare Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.23 Nursing Services 42 CFR 482.28 Food and Dietetic Services .	{E 000}		

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{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: . Based on observation, interview, and document review, the hospital's governing body failed to provide effective oversight of the hospital. Failure to provide effective oversight to prevent substandard practices for nursing services and food and dietetic services resulted in an unsafe environment for patients. Findings included: Cross Reference: A0405 The Governing Body failed to effectively provide oversight of the hospital services to protect patients from harm as evidenced by the IMMEDIATE JEOPARDY condition identified on 04/02/19 for failure to ensure allergies were verified prior to preparation and administration of medications. Cross Reference: A0620, A0629 Failure to provide for the nutritional needs of patients, including dietary modifications resulting from diagnosis, disease, or lifestyle choice, and providing effective oversight of dietary	{A 043}		

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{A 043}	Continued From page 1 department functions. Due to the scope and severity and scope of the deficiencies detailed under 42 CFR 482.23 Condition of Participation for Nursing Services and 42 CFR 482.28 Condition of Participation for Food and Dietetic Services, the Condition of Participation for Governing Body was NOT MET under 42 CFR 482.12. .	{A 043}		
{A 068}	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedure, the hospital failed to ensure staff followed their medication reconciliation process. Failure to consider continuing medications used	{A 068}		

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{A 068}	Continued From page 2	{A 068}		

by the patient at home for chronic illnesses, risks poor care continuity and patient safety.

Findings included:

1. Document review of the hospital policy and procedure titled, "Medication Reconciliation," no policy number, effective 05/17, showed that all medications the patient has been regularly taking at home will be documented in the medical record at the time of admission. A list of all patient home medications will be obtained by the nursing staff during the process of completing the admission nursing assessment.

The physician will make the clinical decision to either continue or discontinue the patient's home medications. This will be documented in the medical record either on the admission order sheet or in the physician progress note.

2. On 04/04/19 at 4:00 PM, Surveyor #3 reviewed the medical record of Patient #301 who was admitted involuntarily for an acute behavioral decompensation on 12/11/18. The review showed:

- A Medication Reconciliation form completed upon admission listed only four medications used by the patient at home. Those medications were Adderall (a stimulant used for attention deficit disorder), Gabapentin (a medication used for nerve pain or seizures), Seroquel (an antipsychotic medication), and Vilbryd (an antidepressant medication).

- The Medical Admission History and Physical completed on 12/12/18 showed the patient's non-psychiatric medical problems were

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{A 068}	Continued From page 3	{A 068}		

hypertension (high blood pressure), asthma, glaucoma, and migraines. Non-psychiatric medications used by the patient included Latanoprost (used to treat glaucoma), Metoprolol (medication used to treat high blood pressure), Amlodipine (medication used to treat high pressure), Prilosec (medication used to treat gastrointestinal reflux disease) and Ocella (birth control medication used to treat ovarian cysts and irregular menstrual cycles).

-On 12/12/18 at 11:55 AM, a provider ordered Patient #301's high blood pressure medications Metoprolol and Amlodipine.

-On 12/20/18 at 11:23 AM, a provider ordered a medical consultation for patient's concerns for "heavy menstrual period due to ovarian cysts, chronic eye condition and GI conditions (Patient was on some meds for these conditions, please review the meds with her)".

-On 12/20/18 at 12:15 PM, a provider ordered Patient #301's previous home medications of Latanoprost, Prilosec, and Ocella.

3. On 04/05/19 at 11:00 AM, Surveyor #3 interviewed the Chief Medical Officer (CMO) (Staff #304) about the medication reconciliation process. Staff #304 stated that the medical practitioner (provider who treats non-psychiatric conditions of the patient at the psychiatric hospital) is responsible for reviewing the medications that the patient is on at home and ordering those medications unless there is a contraindication. The surveyor reviewed the medical record with the CMO and asked if there were any reason why the medication used by the patient to treat their glaucoma was not continued

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{A 068}	Continued From page 4 upon admission to the hospital. He stated it "looks like we just missed this, we should have continued this". .	{A 068}		
A 123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION CFR(s): 482.13(a)(2)(iii) At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: . Based on document review and interview, the hospital failed to provide written notification to complainants in response to grievances. Failure of the hospital to provide written notice of the outcome of their grievance investigation, and steps taken on behalf of the patient or the patient's family to investigate the grievance violates their right to be informed of how the hospital investigated and resolved the grievance. Findings included: 1. Document review of the hospital's policy titled, "Grievances and the Patient Advocate," effective date 5/17, showed that that each patient and others making a complaint will receive a response from the facility staff that addresses the complaint within 1 week and written responses to	A 123		

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grievances are to be provided within 30 days of the filed grievance.

2. On 04/04/19, Surveyor #5 reviewed the discharge medical record for Patient #506 who was admitted on 02/03/19 for the treatment of Schizophrenia, suicidal ideation, and medication non-compliance. The record review showed:

-On 02/19/19 at 2:24 PM, an Inpatient Progress note completed by a Program Manager (Staff #509) showed that the complainant had contacted the hospital via phone related to concerns about the patient's discharge plan. Staff #509 documented that she provided the complainant with her fax number and documented that she told the complainant she would forward the fax to the patient's treatment team.

-An undated typed document from the complainant titled, "Postscript after speaking with Staff #509 stated, "We do not think this discharge plan is safe," and asked the facility to assist them to create a good discharge plan together.

On 02/19/19 at 4:48 PM, the Program Manager (Staff #509) documented that she had received the fax from the complainant and would send to the patient's treatment team.

Surveyor #5 found no evidence in the record the complainant received a response from the facility staff that addressed the complaint or a written response to the grievance within 30 days of the filed grievance.

3. On 04/04/19, Surveyor #5 reviewed the hospital's grievance log. Surveyor #5 found no

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A 123	Continued From page 6 evidence the grievance coordinator documented the written complaint or resolution on the hospital's grievance log. 4. On 04/04/19 at 2:00 PM, the Director of Clinical Services (Staff #508) stated that the patient was discharged on a court release; and the treatment team only met once a week and did not meet again prior to the patient's discharge. She stated that she was unsure of the complaint resolution and verified it was not logged onto the hospital's grievance log. .	A 123		
{A 273}	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	{A 273}		

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This STANDARD is not met as evidenced by:
.
Based on interview, review of the hospital's quality program and review of quality documentation, the hospital failed to ensure that data regarding medication errors were analyzed for patterns, trends, and common factors and reported through the hospital's quality program.

Failure to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care.

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.

The hospital will utilize comparison of outcome and process data to ensure that the same level of care is provided regardless of the location in the hospital where care is provided.

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Document review of the hospital's plan of correction titled, "Smokey Point Behavioral Hospital survey ending 1/17/19 revised 3/1/2019," showed that Pharmacy and Therapeutic Committee and Pharmacy will report their aggregated and analyzed data to the Process Improvement committee on a monthly basis.

2. On 04/04/19 from 4:00 PM until 5:30 PM, Surveyor #5, Surveyor #11, the hospital's Chief Executive Officer (Staff #511), Director of Clinical Services (Staff #508), Chief Nursing Officer (Staff #510), Medical Director (Staff #512), Vice President of Clinical Support (Staff #513), and the Sr. Vice President of Compliance and Clinical for US Health Vest (Staff #514) reviewed the hospital's quality program. The review showed:

-Surveyor #5 found no evidence aggregated and analyzed medication error data was reported to the hospital's Quality Committee.

4. At the time of the review, the Chief Executive Officer (Staff #511) and the Chief Nursing Officer (CNO) (Staff #510) stated that the Pharmacy and the CNO met weekly to review medication errors and that the information had been reported to the Quality committee. Staff #510 and #511 reviewed the meeting minutes and verified there was no documentation to show the data has been reported through the Quality Committee or any action plans developed based on the analysis of this data.

5. On 04/05/19 at 1:00 PM, Staff #510 presented the surveyor with a draft of the Medication Safety Plan, Medication Safety Committee Charter, Medication Safety Committee Minutes dated 01/23/19, and a Medication Error Summary dated

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{A 273}	Continued From page 9 01/19. At this time, she stated that the errors were being reviewed by herself and Pharmacy, but she was not able to produce monthly reports for the Surveyor to review. .	{A 273}		
{A 308}	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21 ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: . Based on interview, document review, and review of the hospital's quality and performance improvement program, the hospital failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan. 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 adverse patient outcomes. 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	{A 308}		

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hospital collects, aggregates, and uses statistical analysis 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 ensure coordination and integration of all quality improvement activities by the PI Committee to ensure that all quality improvement information will be exchanged and monitored.

Document review of the hospital's plan of correction titled, "Smokey Point Behavioral Hospital survey ending 1/17/19 revised 3/1/2019," showed that "Directors were given copies of their clinical contracts to review and aggregate data to present to the Chief Financial Officer (CFO) for contract renewal and review by the PI Committee. A job posting has been created to hire a person to review and collect data on contracting services. The employee will review expectations and monitor performance on a monthly basis and create a report to the CFO to be presented to the PI committee at least once a year."

2. On 04/04/19 from 4:00 PM until 5:30 PM, Surveyor #5, Surveyor #11, the hospital's Chief Executive Officer (Staff #511), Director of Clinical Services (Staff #508), Chief Nursing Officer (Staff #510), Medical Director (Staff #512), Vice President of Clinical Support (Staff #513), and the Sr. Vice President of Compliance and Clinical for US Health Vest (Staff #514) reviewed the hospital's quality program. The review showed:

-Surveyor #5 reviewed three clinical contract evaluations. Surveyor #5 noted that the evaluations were completed using a standardized

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{A 308}	Continued From page 11 template. The evaluation matrix assigned were generic and not individualized to the service provided. Surveyor #5 found no evidence the contract performance evaluation performed for any clinical contracts had been reported to the hospital's Quality Committee. 3. At the time of the review, Staff #510 and Staff #514 confirmed the findings. .	{A 308}		
{A 385}	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: . Based on record review, interviews, and document review, the hospital failed to ensure hospital staff members followed hospital policy for preparing and administering medications and standards of practice. Failure to follow hospital policy and procedure when preparing and administering medication places patients at risk for medication errors, injury, or death. Findings included: Cross Reference: A0405 On 04/02/19 at 5:20 PM, the surveyors notified hospital administrators that a state of Immediate Jeopardy existed due to a systemic failure of staff	{A 385}		

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{A 385}	Continued From page 12 members to the follow standards of practice and hospital policy and procedure for allergy verification prior to preparation and administration of medications. Cross Reference A0392 Failure to provide nursing care based on patient assessments and physician orders. Due to the scope and severity of deficiency cited under 42 CFR 482.23 the Condition of Participation for Nursing Services was NOT MET. .	{A 385}		
{A 392}	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: . Based on interview and document review, the hospital failed to ensure that nursing staff members had appropriate resources available to implement physician orders (Item #1), and failed to ensure nursing staff assessed skin integrity, and documented wound care assessments (Item #2) for 1 of 2 discharged patients reviewed (Patient #502). Failure to provide nursing care based on patient	{A 392}		

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assessments and physician orders places patients at risk for deterioration of health status and poor health care outcomes.

Item #1- Resources

Findings included:

1. On 04/05/19 at 1:30 PM, Surveyor #5 reviewed the discharged medical record for Patient #505, who was admitted on 01/26/19 for the treatment of suicidal ideation. The record review showed:

-The New Admission Medical History and Physical completed on 01/27/19 at 9:30 AM showed the patient was paraplegic and wheelchair bound, and the patient was diagnosed with anorexia (an eating disorder). The provider documented on this form that the patient needed an egg crate mattress (pressure reducing cushion) as she was at risk for "pressure sores."

-On 02/11/19 at 10:20 AM, a provider ordered the staff to place 2 layers of egg crate mattress cut to fit as a wheelchair cushion.

-On 02/12/19 at 10:25 AM, a provider wrote an order that stated, "Please follow orders per IM on 2/11/19. I don't see egg crate foam on patient's wheelchair. She has a pressure ulcer." Surveyor #5 observed a Registered Nurse wrote next to this provider entry the following, "Per housekeeping there are no egg crate mattresses in the house. We should simply buy her a wheelchair cushion at Walmart."

-Documentation on a Nurse Note completed on 02/12/19 at 7:00 PM, stated, "Requested egg crate from housekeeping but none in house.

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Suggested we buy a wheel chair cushion from Walmart."

-Surveyor #5 found no evidence the patient received the pressure-reducing cushion.

2. On 04/05/19 at 2:35 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the medical record and discussed the Surveyors findings. Staff #507 stated that she was aware of this patient, and that the patient did not receive the egg crate for her wheel chair.

Item #2 - Assessment and Documentation

Findings included:

1. Document review of the hospital's clinical policy and procedure manual titled, "Lippincott Williams & Wilkins," showed that when a wound is identified it must be assessed and documented for etiology, location, size (length X width X depth), wound bed, exudate, odor, condition of the surrounding skin, clinical signs of a critical colonization, and include patient concerns.

Document review of the hospital's policy and procedure titled, "Nursing/Medical Procedures," no policy number, effective 05/17, showed that for procedures, the nurse will follow the physician order, follow applicable hospital policy and procedure, and utilize the Lippincott Manual as a reference guide to conduct procedures.

2. On 04/05/19 at 1:30 PM, Surveyor #5 reviewed the discharged medical record for Patient #505, who was admitted on 01/26/19 for the treatment of suicidal ideation. The record review showed:

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-On 02/11/19 at 10:20 AM, a provider ordered the staff to apply Zinc Oxide to the patient's coccyx twice daily for a pressure ulcer. Document review showed that this order was the first documentation that the patient had developed a pressure ulcer.

-Documentation on a Nursing Note completed on 02/13/19 for the period 7:00 AM to 7:00 PM, showed that the patient's pressure sores had improved with only one on the right buttocks measuring 0.5 by 0.7. The pressure ulcer had no drainage or signs of infection.

Surveyor #5 found no evidence that nursing staff completed a wound assessment upon discovery of the wound, and no further documentation that the wound was being monitored, measured, or reassessed for healing.

3. On 04/05/19 at 2:35 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the medical record and discussed the surveyor's findings. Staff #507 stated that the hospital staff had not followed the hospital's policy and procedure for preventing, assessing, measuring, and documenting the pressure ulcer. At this time, Surveyor #5 noted the nursing note completed on 02/17/19 described the ulcer. Staff #507 stated that she had gone to the department and reminded the staff to document the wound assessment. Surveyor #5 noted that the Nurses Daily Assessment did not include a section for skin or wound assessment. Staff #507 verified the document did not include a skin or wound assessment and stated that the hospital did not have a wound assessment form, but they had identified this as an issue and were developing a tool.

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{A 396}	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD 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 1 of 2 discharged patients reviewed (Patient #505). 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 procedure titled, "Treatment Planning," no policy number, effective date 05/17, showed that following the nursing assessment, the Registered Nurse would 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. 2. On 04/05/19 at 1:30 PM, Surveyor #5 reviewed the discharged medical record for Patient #505, who was admitted on 01/26/19 for the treatment	{A 396}		

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of suicidal ideation. The record review showed:

-The Initial Nursing Assessment completed on 01/27/19 at 8:00 AM, showed the patient was paraplegic, weighed 70 pounds, and did not have a pre-existing pressure ulcer.

-The Psychiatric Evaluation completed on 01/27/19 at 1:00 PM, showed the patient was paraplegic and used a wheelchair for mobility.

-The New Admission Medical History and Physical completed on 01/27/19 at 9:30 AM showed the patient was paraplegic and wheelchair bound, and the patient was diagnosed with anorexia (an eating disorder). The provider documented on this form that the patient needed an egg crate mattress as she was at risk for "pressure sores."

-On 01/27/19 at 3:00 PM, a provider ordered a egg crate mattress (a pressure reducing device) for the patient.

-On 02/11/19 at 10:20 AM, a provider ordered the staff to place 2 layers of egg crate mattress cut to fit as a wheelchair cushion, and for Zinc Oxide ointment applied to the coccyx pressure ulcer twice daily.

-On 02/12/19 at 10:25 AM, a provider wrote an order that stated, "Please follow orders per IM on 2/11/19. I don't see egg crate foam on patient's wheelchair. She has a pressure ulcer." Surveyor #5 observed a Registered Nurse wrote next to this provider the following, "Per housekeeping there are no egg crate mattresses in the house. We should simply buy her a wheelchair cushion at Walmart."

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{A 396}	Continued From page 18 -Surveyor #5 found no evidence the hospital acquired pressure ulcer, treatment of the ulcer, or preventative measures ordered by the provider were added to the patient's plan of care. 3. On 04/05/19 at 2:35 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the medical record and discussed the surveyor's findings. Staff #507 stated that the patient had received the egg crate for the bed, but did not receive the egg crate for her wheel chair. Staff #507 verified that staff had not updated the care plan to include the pressure ulcer, and stated that the hospital staff had not followed the hospital's policy and procedure for preventing, or measuring and documenting the pressure ulcer. .	{A 396}		
{A 405}	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing	{A 405}		

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{A 405}	Continued From page 19 or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedure, the hospital failed to ensure that hospital staff members followed its procedures for: allergy verification of patients (Item #1); high alert medications (Item #2); missed medications (Item #3); wasting of controlled substances (Item #4); and adherence to physician driven clinical protocols for alcohol withdrawal (Item #5) during the process of medication preparation and administration. Failure to follow the hospital's preparation and medication administration process places patients at risk for medication errors and patient harm. Item #1 - Allergy Verification Findings included: 1. Document review of the hospital policy and procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse communicates with the ordering practitioner regarding any question relating to a medication order. Document review of the hospital policy and procedure titled, "Medication Orders," no policy number, effective 12/16, showed that the pharmacist on duty reviews each medication order for dosage, drug-drug interaction, patient	{A 405}		

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allergies, and contraindications. The medication nurse will be contacted immediately of any clarifications needed. Medications will not be administered until clarified. The physician will be contacted and an order written to clarify the problem. All interventions by the pharmacy will be documented on the Medication Intervention Log.

Once clarified, the pharmacist will verify the physician order and add the medication to the pharmacy medication profile and dispense the medication in accordance with standard medication dispensing processes. The nurse receiving the medication from the pharmacy will serve as verification of all orders by the pharmacist for the nursing staff.

2. On 04/02/19 at 10:30 AM, Surveyor #5 and a Registered Nurse (Staff #501) reviewed the medical record for Patient #501 who was admitted for the treatment of mania, suicidal ideation, and bipolar disorder. The record review showed:

-The Smokey Point Behavioral Hospital Intake Assessment completed on 03/31/19 at 6:40 AM, showed that Patient #501 was allergic to the medication Lorazepam (a medication used to treat anxiety).

-The Allergies Worksheet, completed at the time of admission, showed that Patient #501 was allergic to the medication Lorazepam.

-The Medical Admission History and Physical competed on 03/31/19 at 8:15 AM, showed that Patient #501 was allergic to the medication Lorazepam.

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-The Psychiatric Evaluation dictated on 03/02/19 at 5:00 PM, showed that Patient #501 was allergic to Lorazepam.

-The allergy section of the medication administration records dated for the period 03/31/19 through 04/02/19 showed that Patient #501 was allergic to the medication Lorazepam.

-The allergy section of the provider orders for the period 03/31/19 through 04/02/19 showed that Patient #501 was allergic to the medication Lorazepam.

-On 03/31/19 at 10:20 AM, a provider ordered Diphenhydramine (an antihistamine) 50 mg by intramuscular injection (IM), Lorazepam 2 mg IM, and Haloperidol 5 mg IM (a major antipsychotic).

On 03/31/19 at 10:21 AM, the medication administration record showed the patient received Diphenhydramine 50 mg IM, Lorazepam 2 mg IM, and Haloperidol 5 mg IM.

-On 03/31/19 at 9:00 PM, a provider ordered Diphenhydramine 50 mg to be taken orally (PO), Lorazepam 2 mg PO, and oral Haloperidol 5 mg PO.

-On 03/31/19 at 9:00 PM, the medication administration record showed the patient received Diphenhydramine 50 mg PO, Lorazepam 2 mg PO, and Haloperidol PO.

-The Daily Nursing note dated 03/31/19 showed that on the day shift, the patient was medicated and placed in restraints related to violent behavior. The night shift nursing note stated that staff had medicated the patient with a "B52 PO."

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4. On 03/31/19 at 11:06 AM, Surveyor #5 interviewed a Registered Nurse (RN) (Staff #501) about what a"B52" was. Staff #501 stated that a "B52" was a medication cocktail of Diphenhydramine, Lorazepam, and Haloperidol. Surveyor #5 asked the RN if she was aware the patient was allergic to Lorazepam and showed the RN the documentation in the medical record. The RN stated that the patient had stated she was allergic to Lorazepam, but the allergy had not been verified. The nurse verified the patient had received the medications.

5. On 04/02/19 at 1:30 PM, Surveyor #3 interviewed the Pharmacy Director (Staff #301) about the medication review process by a pharmacist. Staff #301 stated that a pharmacist reviews all new medication orders prior to being added on the patient's medication profile system and subsequently the printed medication administration record. This review includes medications given emergently or administered after overriding the automated drug cabinet safety features. The medication review process includes a verification of the patient's drug allergies.

The Pharmacy Director (Staff #301) stated that the patient's medication profile system will "flag" or alert the reviewing pharmacist of any known drug allergies recorded for the patient. The pharmacist will clarify any concerns and document actions taken before verifying and approving the medication being added to the patient's medication profile.

6. Review of the pharmacy document titled, "Medication Screening Audit Reports," for the period 03/30/19 to 04/02/19 showed that Patient

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#501's medication order for Lorazepam injectable written at 03/31/19 at 10:20 AM had a screening alert message for Lorazepam. That message stated, "The use of Lorazepam injection . . . may result in an allergic reaction based on a reported history of allergy to LORAZEPAM." The document showed the pharmacist acknowledged the alert screening. The pharmacist then placed the drug on the patient's medication profile making the drug available to the nursing staff to administer to the patient.

Patient #501 had an additional medication order written on 03/31/19 at 9:00 PM for a Lorazepam tablet written at 03/31/19 at 9:00 PM. This medication order was reviewed retrospectively by the after-hours off-site pharmacist approximately 30 minutes after it was administered by the nurse. The afterhours off-site pharmacist acknowledged the alert screening and overrode the allergy-screening alert. No documentation could be found on the off-site pharmacy service electronic communication log to indicate the reviewing pharmacist had clarified the allergy-screening alert.

The Pharmacy Director (Staff #301) could find no documentation that the reviewing pharmacist had clarified the allergy-screening alert with the ordering provider or a licensed nursing staff member before placing the drug on the patient's medication profile. Staff #301 confirmed the above findings.

7. Review of the pharmacy document titled, medication "Profile Override," for the period 03/31/19 to 04/01/19 showed the retrospective review completed by a pharmacist on 04/02/19. The document showed that Lorazepam ordered

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on 03/31/19 at 9:00 PM for Patient #501 was documented "OK" indicating no concerns for allergy verification or nursing staff overriding the safety features of the automated drug cabinet.

Item #2 - High Alert Medications

Findings included:

1. Document review of the hospital's policy titled, "Insulin Medication Administration," no policy number, effective 05/17, showed that after the first nurse draws up insulin, a second nurse inspects it and both nurses are to sign the medication administration record (MAR). The nurse will record the measured blood glucose level, the amount of insulin injected and the time the medication was administered on the MAR.

2. During record review, Surveyor #9 reviewed Patient #902's MAR for administration of Lantus Insulin (slow acting insulin) which was ordered to be given once a day. Document review of the MAR from 03/16/19 to 04/01/19 showed no documentation that a two-nurse verification was completed for 10 of 17 administrations of Lantus Insulin.

3. During record review on 04/03/19, Surveyor #9 reviewed the administration of Humalog Insulin (fast acting insulin) sliding scale medication orders (sliding scale refers to the progressive increase in pre-meal or nighttime insulin doses based upon a pre-defined blood glucose ranges) for Patient #902 from 03/16/19 to 04/01/19. The review showed that 18 of 44 medication administrations of sliding scale insulin were not documented according to hospital policy by failing to include both the blood glucose level and the

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number of insulin units administered.

4. At the time of the review, Surveyor #9 discussed the finding with the Unit Director (Staff #901) and she agreed that the nursing staff had failed to follow the hospital's policy for documenting sliding scale insulin administration.

Item #3 - Missed Medications

Findings included:

1. Document review of the hospital policy and procedure titled, "Medication Administration," no policy number or effective date, showed that all missed medications or late administration of medications must be reported to the physician, pharmacist, and a variance report submitted to the Performance Improvement Director by the Chief Nursing Officer. The variance report will include the reason for missing the dose (patient refusal, patient unavailable, medication unavailable, human error, etc) and the actions taken.

2. Surveyor #3 reviewed Patient #301's medical record. The review showed:

a. A physician ordered Latanoprost ophthalmic solution (a medication used to treat glaucoma) one drop to each eye at bedtime for the patient on 12/20/18 at 12:15 PM.

b. The medication administration record (MAR) showed for the period 12/20/18 to 12/24/18 that the medication as "unavailable" and was not given for four consecutive days.

3. On 04/05/19 at 9:15 AM, Surveyor #3

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interviewed a staff pharmacist (Staff #302) about the medication Latanoprost ophthalmic solution. Staff #302 stated the medication was on the hospital formulary and was stocked in the Pharmacy. If medications were unavailable or out of stock, they were ordered and delivered that day or the following day. She was unaware of any problems obtaining the medication.

4. On 04/05/19 at 3:00 PM, Surveyor #3 interviewed the Chief Nursing Officer (CNO) (Staff #303) about the actions hospital staff should take when medications are unavailable. Staff #303 stated the nursing staff should contact hospital leadership for assistance if problems occur. She said that an email was sent to staff reminding them to not simply document medications were unavailable on the MAR without notifying hospital leadership. She was unaware of Patient #301 not receiving her eye medications. She confirmed that no variance reports were submitted for this patient for unavailability of a medication.

Item #4 - Wasting of Controlled Substances

Findings included:

1. During closed record review, Surveyor #9 reviewed the record of Patient #903. The review showed that the nurse (Staff #902) obtained a verbal telephone order on 01/27/19 at 9:10 PM for Lorazepam (a medication used to treat convulsions) 2 mg intramuscularly for seizure activity. The patient's allergies listed on the "Provider Orders" form included Lorazepam. The physician (Staff #903) verified and signed the order on 01/28/19 at 7:15 AM. Review of the medication administration record (MAR) and

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nursing notes did not show administration of the medication Lorazepam.

2. On 04/05/19 at 9:30 AM, Surveyor #3 requested a medication profile override list from the pharmacy. The document review shows that the nurse (Staff # 902) removed Lorazepam 2 mg injectable as a medication override from the Automated Drug Cabinet at 9:21 PM. The review showed that the Lorazepam 2 mg was "wasted" (discarded) at 10:45 PM by a different nurse (Staff #904) and witnessed by a second nurse (Staff #905). The waste reason stated, "Patient states he's allergic to Ativan" (trade name for Lorazepam).

3. On 04/05/19 at approximately 2:30 PM, Surveyor #9 discussed the finding with the Chief Nursing Officer (Staff #906). She stated that the wasting of the Ativan should be documented on the MAR with the explanation of patient's allergy.

Item #5 CIWA Protocol

Findings included:

1. Document review of the hospital's policy and procedure titled, "CIWA [Clinical Institute Withdrawal Assessment of Alcohol]," no policy number, effective date 06/2018, showed that providers would order the use of a CIWA scale to monitor the severity of withdrawal symptoms and guide potential preventative therapy. For a patient who is in or expected to be in withdrawal from alcohol, the provider may order medications according to the symptoms, CIWA score, or both.

Document review of medication orders showed that the physician ordered Librium 50 mg (a

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{A 405}	Continued From page 28 medication used to treat anxiety) orally for a CIWA score greater than eight. 2. During a closed medical record, Surveyor #9 found that on 04/01/19 Patient #901 had a CIWA score of 9 at 11:50 AM, a score of 9 at 3:50 PM, and a score of 10 at 5:30 PM. A document review of the medication administration record (MAR) showed that the patient did not receive the medication Librium as ordered following the 9:50 AM and 5:30 PM assessments of the CIWA score. 3 At the time of the review, Surveyor #9 discussed the finding with the Unit Director (Staff #901) and she agreed the licensed nursing staff had failed to follow the CIWA protocol as ordered. .	{A 405}		
A 618	FOOD AND DIETETIC SERVICES CFR(s): 482.28 The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: . Based on observation, document review, and	A 618		

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interview, the hospital failed to ensure dietary modifications related to disease, food allergy, or lifestyle were communicated, implemented, and provided to its patients, and failed to provide oversight of non-dietary staff performing dietary functions.

Failure to provide for the nutritional needs of patients, including dietary modifications resulting from diagnosis, disease, or lifestyle choice, and providing effective oversight of dietary department functions risks patients receiving inadequate nutrition, patient harm, and patient death and resulted in an unsafe environment for patients.

Findings included:

Cross Reference A0620:

Failure to provide supervision of personnel providing dietary services, and implementing policies and procedures that ensure that patients with food allergies or other special dietary needs are implemented, risks patients receiving improper nutrition that could lead to unanticipated patient outcomes, harm, and death.

Cross Reference A0629:

Failure to ensure that patients requiring dietary modifications receive the appropriate diet risks improper nutrition that could lead to unanticipated patient outcomes, harm, and death

Due to the scope and severity of the deficiencies detailed under 42 CFR 482.28, the Condition for Participation for Food and Dietetic Services was NOT MET.

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A 620	DIRECTOR OF DIETARY SERVICES CFR(s): 482.28(a)(1) The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This STANDARD is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure that a dietician responsible for the daily management of dietary services, implemented training programs for non-dietary staff performing dietary functions. Additionally, the hospital failed to ensure that established policies and procedures were implemented that addressed supervision of work by non-dietary personnel performing dietary functions. Failure to provide supervision of personnel providing dietary services, and implementing policies and procedures that ensure that patients with food allergies or other special dietary needs are implemented, risks patients receiving improper nutrition that could lead to unanticipated patient outcomes, harm, and death. Findings included: 1. Document review of the hospital's policy and	A 620		

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procedure titled, "Food Allergies," no policy number, effective 05/17, showed that a Registered Nurse (RN) needs to ensure that the foods the patient is allergic to are not available to the patient either on the tray or for snacks. The Food Service Manager will check all foods for the patient (including snacks) to ensure the patient is not given food they are allergic to.

Document review of the hospital's policy and procedure titled, Nourishment between Meals," no policy number, effective date 05/17, showed that special snacks will be written by the dietician and recorded on the special snack list. The dietary aide will prepare the snacks, label them, and place them in the bin with the general snacks for each unit. The dietician oversees food items used for snacks and plans special snacks when appropriate for clients following a modified diet. The dietician is responsible for updating the special snack list. The dietician instructs dietary aides about special dietary restrictions.

2. On 04/02/19 at 10:30 AM, Surveyor #5 observed a dietary staff bring a gray bin filled with snacks, and place it on the front nurse's station desk and then leave. A Mental Health Technician (Staff #504) gave the patient's their snacks after the patients looked in the bin and requested their snack.

3. On 04/02/19 at 10:40 AM, during the mid-morning snack period, Surveyor #5 observed a Mental Health Technician (Staff #504) give Patient #501 a snack that was labeled as "100% Whole Wheat." Surveyor #5 observed the patient open and then ingest the 100% Whole Wheat snack.

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At this time, Surveyor #5 immediately asked Staff #504 if she was aware of the patient's food allergies. Staff #504 stated she was not sure what all the allergies were and that she would need to review the medical record. Surveyor #5 showed Staff #504 the allergy documentation in the medical record which showed an allergy to wheat. At that time, Staff #504 took the remaining snack away from the patient. Staff #504 did not review the dietary card prior to providing the wheat-containing snack. Surveyor #5 did not observe any labeled snacks inside the bin for patients with diet modifications or allergies. Surveyor #5 did not observe any RN or dietary oversight from the dietary manager during the snack process.

4. On 04/02/19 at 10:49 AM, Patient #502 presented to the nurse's station and asked for "Sun Chips" for his midmorning snack. Staff #501 and a Mental Health Technician (Staff #502), paused and told the patient they did not know if he could have them, and they would need to review the diet order for carbohydrate restriction. At the time, the patient appeared confused that he was no longer allowed "Sun Chips" and stated that he could have them, but if not he would have popcorn. Surveyor #5, Staff #501, and Staff #502 were unable to locate a carbohydrate range in the medical record. Staff #501 confirmed the provider ordered the patient to receive low sugar, high protein snacks related to elevated blood sugars.

On 04/03/19 at 10:30 AM, Surveyor # 5 and a Program Manager (Staff #503), reviewed the dietary card for Patient #502. The dietary card did not show that the patient had to receive low sugar, high protein snacks. Staff #503 verified the finding and stated that the staff should have

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A 620	Continued From page 33 updated the dietary card to reflect the dietary modification. 5. On 04/02/19 at 2:00 PM, Surveyor #5 interviewed the Dietician (Staff #505) and the Food Service Manager (Staff #506) about the food allergy findings for Patient #501 and the dietary modifications for Patient #502. Staff #505 stated that it is the nurse's responsibility to review the dietary card for allergies and any diet modifications when providing the appropriate snack. He stated the Food Service Manager did not check the snacks to ensure the patient is not given a food that the patient has an allergy to. Staff #506 stated that the nurses fax the provider diet orders to the food service department and the nurses are responsible for checking the diet card and ensuring the patient does not receive a food they are allergic to. She stated that nursing staff did not receive oversight supervision from Dietary. .	A 620		
{A 629}	THERAPEUTIC DIETS CFR(s): 482.28(b), (b)(1) §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure that patients with medical conditions, medical	{A 629}		

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histories, allergies, and lifestyle choices that required dietary modifications received the appropriate diets for 4 of 4 inpatients reviewed (Patient #501, #502, #503, and #504).

Failure to ensure that patients requiring dietary modifications receive the appropriate diet risks improper nutrition that could lead to unanticipated patient outcomes, harm, and death.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Food Allergies," no policy number, effective 05/17, showed that a Registered Nurse (RN) will ensure that the foods the patient is allergic to are not available to the patient either on the tray or when given out for snacks. The Food Service manager will check all foods for the patient (including snacks) to ensure the patient is not given food the patient is allergic to.

Document review of the hospital's policy and procedure titled, "Nourishment between Meals," no policy number, effective date 05/17, showed that special snacks will be written by the dietician and recorded on the special snack list. The dietary aide will prepare the snacks, label them, and place them in the bin with the general snacks for each unit. The dietician oversees food items used for snacks and plans special snacks when appropriate for clients on a modified diet. The dietician is responsible to update the special snack list.

Patient #501

2. On 04/02/19 at 10:30 AM, Surveyor #5 and a

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Registered Nurse (Staff #501), reviewed the medical record for Patient #501 who was admitted on 03/30/19 for the treatment of suicidal ideation, mania, and bipolar disorder. The record review showed:

The initial nursing assessment nutritional screen completed on 03/30/19 showed that the patient required a nutritional consult for food allergies to soy, wheat/gluten, egg whites, peanuts, and dairy.

-On 03/31/19 at 1:08 AM, staff completed a Dietary Consultation form for food allergies to soy, wheat/gluten, egg whites, peanuts, and dairy.

-The Allergies Worksheet, completed at the time of admission, showed that Patient #501 was allergic to wheat/gluten, egg whites, soy, peanuts, and dairy.

-The Medical Admission History and Physical competed on 03/31/19 at 8:15 AM, showed that Patient #501 was allergic to peanuts, and had a gluten sensitivity.

-The allergy section of the medication administration records for the period 03/30/19 to 04/02/19 showed that Patient #501 was allergic to soy, wheat/gluten, peanuts, and dairy.

On 04/01/19 at 8:15 AM, a dietician completed a Nutritional Assessment Form-Initial. Documentation in the section titled, "Nutritional Diagnosis," showed that the patient had allergies to gluten, peanuts, egg whites, soy, and dairy. The Dietician recommended for the providers to, "1. Continue current diet of multiple food allergies. 2. Provide Ensure PRN as meal replacement."

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3. On 04/02/19 at 10:40 AM, during the mid-morning snack period, Surveyor #5 observed a Mental Health Technician (Staff #504) give Patient #501 a snack that was labeled as "100% Whole Wheat." Surveyor #5 observed the patient open and then ingest the 100% Whole Wheat snack.

At this time, Surveyor #5 immediately asked Staff #504 if she was aware of the patient's food allergies. Staff #504 stated she was not sure what all the allergies were and that she would need to review the medical record. Surveyor #5 showed Staff #504 the allergy documentation in the medical record. At that time, Staff #504 took the remaining snack away from the patient. Staff #504 did not review the dietary card prior to providing the wheat-containing snack. Surveyor #5 did not observe any labeled snacks inside the bin for patients with diet modifications or allergies. Surveyor #5 did not observe any RN or dietary personnel provide oversight during the snack process.

4. Immediately, after Staff #504 took the remaining snack from the patient, Staff #504 turned and walked away from the nurse's station and the patient. Surveyor #5 intervened and asked Staff #504 if she should notify anyone that the patient ingested food she was allergic to. Staff #504 stated she did not know. At this time, an arriving RN (Staff #501) verified the food allergy in the medical record, and stated that she would contact the physician.

Patient #502

3. On 04/02/19 at 9:55 AM, Surveyor #5 and a Registered Nurse (Staff #501) reviewed the

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medical record for Patient #502 who was admitted on 03/01/19, for the treatment of schizophrenia and Dementia. The record review showed:

-The patient was a Type II Diabetic with elevated blood sugars.

-On 03/14/19 at 10:30 AM, a provider ordered a medical consult for elevated evening blood sugars.

-On 03/14/19 at 11:55 AM, a provider completed the medical consultation.

-On 03/14/19 at 3:15 PM, a provider ordered the patient to have low sugar, high protein snacks.

4. On 04/02/19 at 10:49 AM, Patient #502 presented to the nurse's station and asked for "Sun Chips" for his midmorning snack. Staff #501 and a Mental Health Technician (Staff #502), paused and told the patient they did not know if he could have them, and they would need to review the diet order for carbohydrate restriction. At the time, the patient appeared confused that he was no longer allowed "Sun Chips" and stated that he could have them, but if not he would have popcorn. Surveyor #5, Staff #501, and Staff #502 were unable to locate a carbohydrate range in the medical record. Staff #501 confirmed the provider order for low sugar, high protein snacks.

5. On 04/03/19 at 10:30 AM, Surveyor # 5 and a Program Manager (Staff #503), reviewed the dietary card for Patient #502. The dietary card did not reflect that the patient was to receive low sugar, high protein snacks. Staff #503 verified the finding and stated that the staff should have

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updated the dietary card to reflect the dietary modification.

6. On 04/02/19 at 2:00 PM, Surveyor #5 interviewed the Dietician (Staff #505) and the Food Service Manager (Staff #506) about the food allergy findings for Patient #501 and the dietary modifications for Patient #502. Staff #505 stated that it is the nurse's responsibility to review the dietary card for allergies and diet modifications and provide the appropriate snack. Staff #506 stated that the nurses fax the provider diet orders to the food service department.

Surveyor #5 showed the Dietician, (Staff #505) the documentation form in the medical record and noted that the Dietician had documented the patient's allergies to soy and dairy and then recommended the patient drink Ensure (a nutrional shake) as a meal replacement. The ingredients listed on the Ensure container state, "contains milk and soy ingredient." Staff #505 stated that, "(she) must have missed that."

Patient #503

7. On 04/03/19, Surveyor #5 reviewed the medical record for Patient #503 who was admitted on 03/22/19 for the treatment of Bipolar Disorder with Psychosis. Upon arrival to the nursing unit, Surveyor #5 observed on the white communication board under Patient #503's name written "No Pork, No Bugs." The medical record review showed:

The Psychiatric Evaluation completed on 03/22/19 at 4:00 PM showed the patient had a medical history of hypertension (high blood pressure).

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-On 03/24/19, a provider ordered a medical consultation for high blood pressure. The medical provider completed the consultation on 03/25/19 at 8:10 AM.

-On 03/25/19, a provider ordered a 2-gram Sodium restricted diet due to high blood pressure.

-On 03/27/19, a provider ordered a medical consultation for increased blood pressure and ankle edema. A medical provider completed the medical consultation on 03/28/19 at 10:25 AM.

On 04/03/19 at approximately 10:40 AM, Surveyor #5 observed Patient #503 take a fruit cup from the snack bin.

8. On 04/03/18 at 11:23 AM, Surveyor #5 interviewed a nurse Staff #507 and asked how the staff ensured that patients with diet modifications received the correct snacks. Surveyor #5 noted Patient #503 was on a 2 gram Sodium restriction, and that the Surveyor observed the patient taking his own snack from a bin of snacks. Staff #507 stated that the staff were supposed to review the diet card, and that she did not know if a Sodium restriction was just for the meal tray or if it also included snacks.

Patient #504

9. On 04/03/19 at 11:54 AM, Surveyor #5 reviewed the medical record for Patient #504, who was admitted on 03/31/19 for the treatment of suicidal ideation and psychosis. The record review showed:

-On 03/31/19 at 6:34 PM, the Initial Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 04/05/2019

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) COMPLETION DATE
{A 629}	Continued From page 40	{A 629}		

Assessment Part 1 showed the patient was a vegetarian and lactose intolerant. The Nursing Assessment Part 10 titled, "Nutritional Screen" noted that the patient's diet prior to admission was a regular diet. In the nutritional screening section of Part 10, the nurse is required to check the box of any of the conditions that apply. One option listed is Lactose intolerance. Surveyor #5 observed that the nurse did not check that box. Directions on the document state, "Refer patient for a Nutrition Consult when any of the above conditions are checked or the patient has a special dietary need as noted in the screen, i.e. modified diet or multiple food allergies." Further review of the medical record showed that the patient did not receive a Nutritional Consult.

-On 3/31/19 at 9:30 PM, a provider ordered a regular diet.

-On 04/01/19 at 7:15 AM, the medical history and physical showed that the patient was a vegetarian and lactose intolerant. At this time, Surveyor #5 reviewed the Patient's diet card, which showed a regular diet and a hand written note "no pork." Surveyor found no evidence in the medical record of any investigation of the conflicting diet information or that staff or the provider requested a dietary consult.

10. On 04/03/19 at 11:30 AM, during interview with Surveyor #5, a Program Manager (Staff #503) and a nurse (Staff #507) stated that they did not know why the communication board said "no bugs" and verified the patient was on a regular diet, but did not eat pork. At this time, a Mental Health Technician (Staff #502) stated that he also thought the patient did not eat chicken. The medical record showed that the patient was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 04/05/2019

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{A 629}	Continued From page 41 vegetarian. Surveyor #5 found no documentation in the medical record that the patient did not eat pork or chicken. 11. On 04/03/19 at 11:59 AM, Surveyor #5 interviewed Patient #504 about his diet. The patient stated he did not eat pork or chicken, but that he did drink milk. .	{A 629}		
A 837	TRANSFER OR REFERRAL CFR(s): 482.43(d) The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: . Based on record review, interview and review of hospital policy and procedure, the hospital failed to ensure that the discharge and transfer plans and post discharge prescriptions were included in the transfer of Patient #906 to an Inpatient Drug Treatment Facility. Failure to ensure the patient and receiving facility receive a copy of the discharge/transfer documents to include any post discharge prescriptions puts the patient at risk for missed doses of medication and possible harm. Findings included: 1. Document review of the hospital's policy titled, "Discharge Planning," no policy number, effective 05/17, showed that the discharge plan is to prepare the patient and family for the transition of	A 837		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 04/05/2019

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A 837	Continued From page 42	A 837		

care and it should address the Patient's instructions for continued treatment. Additionally, the discharge plan is to include timely and direct communication with transfer of information to programs that are continuing care.

2. During closed record review, Surveyor #9 reviewed the discharge planning and supporting documents of Patient #906. The review showed that only pages 1-3 of a 10 page "Discharge and Transition Plan" appeared to have been faxed; there was no cover page in the record to confirm where the documents had been faxed to. The hospital was not able to locate the remaining seven pages of the discharge and transition plan. Also missing from the discharge documents were copies of the medication prescriptions to be filled after discharge.

3. On 04/05/19 at 11:00 AM, Surveyor #9 discussed her review of Patient #906's discharge and transition documents with the discharge-planning supervisor (Staff #907). Staff #907 confirmed that copies of the complete discharge transition plan and medication prescriptions should be part of the medical record. She attempted to locate the missing information; however, it was not located by the end of the survey. The surveyor noted that the patient was to have had several prescriptions for psychiatric medications as well as prescriptions for Lantus (long acting insulin) and Lispro (short acting) insulin.

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Survey 4/2/2019-4/5/2019

Plan of Correction Received 4/26/19

Plan of Correction Approved 05/20/19 Patient

A 043 Plan of Correction for Each specific deficiency Cited:

The hospital failed to provide effective oversight to prevent substandard practices for patient safety, and patient rights, resulted in an unsafe environment for patients.

Procedure/process for implementing the plan of correction:

- The Governing Board discussed the ongoing issues regarding the CMS findings. Issues identified that the Governing Board addressed were the following:
  - The Board has approved the increase of resources for the facility this included.
  - Creation of new positions for 3 health unit coordinator. In order to organize the functioning on the units.
  - HCS has been implemented in order to eliminate discrepancies with the allergy documentation. Implementation started 5/6/2019
  - The Governing Board directed resources to provide education and re-education as evidenced by nurses and pharmacy department in regards to medication administration, allergy verification, high alert medication, procedures for medications, wasting of controlled substances and CIWA protocol.
- Governing Board reviewed and approved the new process of dietary notification and re-education of non-dietary staff in relationship to food services.
- .

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- The Governing Board in it's bi-weekly meetings will continue to evaluate the effectiveness of these issues.
- Governing Board will convene on a monthly basis with SPBH in order to ensure that the Plan of Correction is effective.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- A member representative of the Governing Board will visit the hospital monthly at a minimum. During the visit a meeting will be held with leadership and staff delegated to carry out activities of the Plan of Correction; to identify progress or lack of progress, and any other needs or considerations.

Individual Responsible:

CEO

Date Completed:

5/17/2019

A 068 Plan of Correction for Each specific deficiency Cited:

The hospital failed to consider continuing medications used by the patient at home

Procedure/process for implementing the plan of correction:

- The Medical Executive Committee was re-educated 4/25/2019 on ensuring that Providers determine and ensure that any new identified medications not yet mentioned by the patient are reviewed and justified as continuing or discontinuing the medications.
- Nurses have been re-educated as to any home medications identified post admission will clearly be communicated to the provider for determination to continue or discontinue the medication(s).

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring,

analysis, and resolution of PI issues.

- Identified nurses by the CNO will audit 16 chart a week and review that all identified symptoms and medications have been reconciled with justification on admit and any further identified medications post admission identified are communicated to the provider for determination to continue or discontinue.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- A member representative of the Governing Board will visit the hospital monthly at a minimum. During the visit a meeting will be held with leadership and staff delegated to carry out activities of the Plan of Correction; to identify progress or lack of progress, and any other needs or considerations.

Individual Responsible:
CEO
Date Completed:
5/8/2019

A 123 Plan of Correction for Each specific deficiency Cited:
The hospital failed to provide written notification to complainants in response to grievances.

Procedure/process for implementing the plan of correction:

- The hospital policy and procedure for Grievances and the Patient Advocate
- Hospital staff were re-educated in team meetings that all complaints and grievances are communicated to the Risk Department for follow up, reporting, acknowledgment, and resolution of the grievance.
- The policy "Grievances and the Patient Advocate" were revised to ensure the most current language.
- A base template was created for acknowledgment and resolution of any concerns as identified regarding responses to ensure HIPPA is not violated, when patients above the age of majority in Washington State decline participation of outside entities.
- All grievances are tracked and logged per policy by Risk and PI department.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- Program Directors or assigned personnel by the program directors will report out 5 days a week of any concerns identified in the weekly meeting to ensure, that the grievance log is accurate and the documentation has been provided.
    - Program Directors will review 16 charts a week. If any complaints or grievances are documented in the medical record, the program therapist will cross reference the grievance log for accuracy.
- If accuracy of reporting and logging grievances drops below 95% in 2 consecutive months, a new plan of correction will be required.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Plan of Corrections will be reported out weekly to the survey team and reported to PI monthly.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Performance Improvement and Risk
Date Completed:
5/17/2019

A 273 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that data regarding medication errors were analyzed and reported to the PI Committee.

Procedure/process for implementing the plan of correction:

- The PI Committee convened met with the Director of Pharmacy and re-educated the director on required documentation needed at PI Committee including severity, which should first be discussed in P&T.
- The Pharmacy Director will participate in the weekly POC meetings and report out aggregated and analyzed data that will be presented in the P&T and PI Committees.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- The Pharmacy Director will participate in the weekly POC meetings and report out aggregated and analyzed data that will be presented in the P&T and PI Committees.
- The Director of PI will coordinate with the Director of Pharmacy in order to ensure that the monthly reporting of the analyzed and aggregated data.
- The Director of PI will also ensure re-evaluation of the data according to the action plan. If the data is not produced, the director of PI will notify the CEO who will document for the contracted service review and notify the point of contact at the contracting company.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Plan of Corrections will be reported out weekly to the survey team and reported to PI monthly.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of PI
Date Completed:
5/17/2019

A 308 Plan of Correction for Each specific deficiency Cited:
The hospital failed to develop a coordinated process to oversee the performance of contracts by hiring an individual as last cited in the plan of correction.

Procedure/process for implementing the plan of correction:

- Departments were re-educated on completing contracts and requested by the PI Department to begin presenting all annual contracts to the PI committee by the next meeting in May to ensure communication with the Governing Board.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- Contracts will be reviewed by the next PI committee determining the numerator (number of contracts with individualized to the service provided) over the denominator (number of contracts).
- Contracts are to be reviewed for approval that are individualized by 5/16/2019 for report out to the Governing Board.
- Contracts without acceptable results in the indicators will be reported to the GB with recommendations of individualized evaluation metrics for approval and addendum to the identified contracts.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Plan of Corrections will be reported to PI monthly.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Performance Improvement and Risk
Date Completed:
5/17/2019

A 385 Plan of Correction for Each specific deficiency Cited:
The hospital failed to follow hospital policy and procedure when preparing and administering medication.

Procedure/process for implementing the plan of correction:

- Nursing:
  - The day shift nurses on April 2, 2019 were immediately trained on the process for allergy verification. This was completed prior to the completion of the 7a-7p shift.
  - The night shift nurses on April 2, 2019 were immediately trained on the process for allergy verification. This was completed at the beginning of the 7p-7a shift.
  - All other nurses will be trained prior to their next shift, commencing at 7am on April 3, 2019.
- Providers:
  - All providers will be trained prior to their next shift, commencing at 7am on April 3, 2019.
- Pharmacy:
  - The Director of Pharmacy has implemented additional training for all pharmacists regarding drug allergy alerts during order entry. Pharmacist will be trained prior to next work shift, effective immediately.
- All medications to be administered shall be first reviewed by a pharmacist prior to administration, except in the case of an emergency.
- Prior to dispensing any medication, Pharmacy personnel will verify the patient's known allergies. Should an order be received in the Pharmacy for a medication to which the patient is allergic, the Pharmacist will immediately contact the nurse for clarification.
- The nurse will contact the prescribing provider to notify him/her about the allergy and seek clarification of whether to discontinue the order. An order will be written based on that conversation.
- Any removal of allergies requires a written order from the provider.
- Whenever a nurse calls to obtain a telephone order for any medication, the nurse will recite the known allergies for that patient to the provider as part of the telephone order process and will document that read back when the order is written onto the revised order form.
- Prior to administering any medication, the nurse will verify allergies on the MAR against the medications listed on the MAR.
- The nurse administering the medication will document on the MAR all medications given and/or refused, as appropriate.
- The Pharmacist will review an override report each weekday of medications given by override during the previous day. Her review will include whether the patient had any allergies to any medications administered by override. The Pharmacist will report her analysis on a daily basis to the CEO and CNO and to the Governing Board on a weekly basis.
- Pharmacy will also conduct their own retrospective review of medication overrides and report their findings daily to the CEO and CNO.
- An immediate clarification order will be obtained and documented in the comments section, along with the reason the code "RX," which is defined as "Reviewed by pharmacist." It must specify the override reason.

- The Medication Order Form was revised to include that the nurse read back the patient's allergies to the provider whenever calling for a telephone order for a medication.
- Medhost updated the code so that it doesn't remove any allergies from those transactions.
- SPBH will review other electronic opportunities for identifications of allergies other than MedHost.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- For at least the next 30 days, the CNO will monitor medication overrides daily (weekdays) and report her findings (to include whether any medications were administered for which there was a known allergy) to the CEO daily (weekdays) and to the Governing Board weekly. If there are no errors found during this 30-day period, the hospital will seek guidance from the Governing Board on an adjusted frequency of monitoring.
- For at least the next 30 days, Pharmacy will monitor all known medication allergies against medication orders and report their findings weekdays to the CEO & CNO. Any orders which were written for a known medication allergy will result in clarification of the order and a full investigation on how this was missed. If there are no errors found during this 30-day period, the hospital will seek guidance from the Governing Board on an adjusted frequency of monitoring.
- For at least the next 30 days, a daily review of existing patient charts by pharmacy will occur to ensure that no current medications are in conflict with the patients' known allergies, if any conflict is found the provider will be contacted immediately. This will be documented and recorded daily and findings reported to the CEO and CNO. An analysis of this information will be reported at the P&T Committee Meeting and Governing Board. If there are no errors found during this 30-day period, the hospital will seek guidance from the Governing Board on an adjusted frequency of monitoring.
- The Director of Nursing and Director of Pharmacy will report findings from audits on a weekly basis to survey team meeting until the Governing Board recommends an adjusted frequency on monitoring.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Plan of Corrections will be reported out weekly to the survey team and reported to PI monthly.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/16/2019

A 392 Item #1 Plan of Correction for Each specific deficiency Cited:
The hospital failed to provide nursing care based on patient assessments and physician orders by not having the necessary requested items.

Procedure/process for implementing the plan of correction:

- The CNO has re-educated staff assigned to ordering and purchasing that egg-crate cushions are ordered and have enough in house.
- An inventory report will be provided to the CNO on a weekly basis to ensure enough standard purchase items are in the hospital at all times.
- The CNO re-educated nursing staff that any items ordered and transcribed should be identified if available in house and if not the nurses supervisor notified immediately to ensure timely delivery and ordering of items needed for patient care.
-

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- A report of non-standard items required for patient care requiring special ordering will be reported in the weekly survey team meeting to identify if the identified items should be placed on regular ordering.
- An inventory report will be provided to the CNO on a weekly basis to ensure enough standard purchase items are in the hospital at all times.
-

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above reports will be provided to the weekly survey team meeting for report out of any out of stock items ordered by providers.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/16/2019

A 392 Item #2 Plan of Correction for Each specific deficiency Cited:
The hospital failed to provide nursing care based on patient assessments and physician orders by not following policy and procedure for pressure ulcers by re assessment, measuring, and documentation within the medical record.

Procedure/process for implementing the plan of correction:

- The CNO has re-educated nursing on the policy and procedure for pressure ulcers.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- 100% of all identified pressure ulcers diagnosed in the hospital will be audited and reviewed by the CNO or designee for accuracy to the policy including but not limited to
    - Assessment
    - Measuring
    - Documentation in the medical record
- Any non-compliance of 90% or less for 2 consecutive months will require a new plan of correction to be reported to the PI committee.
- Nursing identified in non-compliance will be educated in a non-punitive way for additional education upon identification after the re-education.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above report will be provided to the weekly survey team meeting and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/16/2019

A 396 Plan of Correction for Each specific deficiency Cited:
The hospital failed to update the treatment plan for individualized plan of care.

Procedure/process for implementing the plan of correction:

- RNs were reeducated on the proper procedures of completing MTPs and weekly updates. 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.
- A re-orientation to documentation of treatment plans has been created and all nursing staff will be re-trained in documenting and updating and individualized care plan by 5/16/2019 or have completed prior to the next shift after this date if unable to attend as a group for competency.
- Interdisciplinary nurses and therapists participating in treatment planning will attend a competency re-orientation by 5/16/2019 or have completed prior to the next shift after this date if unable to attend as a group for competency.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- 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.
- Reports on audits of the medical record will be reported by the CNO at the weekly survey team meeting to ensure compliance with the education.
- Nursing identified in non-compliance will be educated in a non-punitive way for additional education upon identification after the re-education.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above report will be provided to the weekly survey team meeting and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/16/2019

A 405 Item #1 addressed in TAG A 385

A 405 Item #2 Plan of Correction for Each specific deficiency Cited:
The hospital failed to follow hospital policy and procedure when preparing and administering insulin medication.

Procedure/process for implementing the plan of correction:

- The CNO re-educated all nursing staff approved for administering medications to the proper policy and procedure for documenting administration of insulin medication. Including but not limited to:
  - Two nurse verification
  - Documenting blood glucose level
  - Number of insulin units administered.
- Any nurse that was not educated by 5/1/2019 will be required to complete the re-education prior to their next shift.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

  - The CNO or designated program manager will randomly audit 100% of diabetic patients with known diagnosis in the hospital for compliance:
    - Two nurse verification
    - Documenting blood glucose level
    - Number of insulin units administered.
- This audit will continue until 100% compliance is achieved for 3 months. After 3 months of 100% compliance a random audit at most of 3 diabetic patients in house will be audited every month for compliance.
- If non-compliance below 90% during the 3 month audit happens a new plan of correction will be required.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Plan of Corrections will be reported out weekly to the survey team and reported to PI monthly.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/17/2019

A 405 Item #3 Plan of Correction for Each specific deficiency Cited:
The hospital failed to consider continuing medications used by the patient at home, thus resulting in medication administration being missed.

Procedure/process for implementing the plan of correction:

- The Medical Executive Committee was re-educated 4/25/2019 on ensuring that Providers determine and ensure that any new identified medications not yet mentioned by the patient are reviewed and justified as continuing or discontinuing the medications.
- Nurses have been re-educated as to any home medications identified post admission will clearly be communicated to the provider for determination to continue or discontinue the medication(s).
- Nurses will be re-educated that the pharmacy is available 24 hours a day 7 days a week and will be also trained to contact the CNO or AOC if not getting resolution on "unavailable medications".

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- Identified nurses by the CNO will audit 16 chart a week and review that all identified symptoms and medications have been reconciled with justification on admit and any further identified medications post admission identified are communicated to the provider for determination to continue or discontinue.
- Monitoring and tracking compliance will be achieved at 3 months of 100% compliance.
- Any reports of "unavailable" medications will be addressed by the Director of Pharmacy and the CNO within 1 business day after immediately resolving the issue upon notification. 16 charts will be audited 5 days a week to ensure no "unavailable" medications were not reported.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- A member representative of the Governing Board will visit the hospital monthly at a minimum. During the visit a meeting will be held with leadership and staff delegated to carry out activities of the Plan of Correction; to identify progress or lack of progress, and any other needs or considerations.

Individual Responsible:
Director of Nursing
Date Completed:
5/20/2019

A 405 Item #4 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to document wasting and rationale of wasting medication on the MAR per policy.

Procedure/process for implementing the plan of correction:

- RNs were re-educated on proper documentation protocol for wasting medications.
- The nurse administering the medication will document on the MAR all medications given and/or refused, as appropriate.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- Pharmacy will provide a discrepancy report to the CNO with within 72 hours of an identified discrepancy for identification of non-documentation.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee on the monthly basis.
- Non-compliance for 2 months of below 95% will require a new plan of correction.
- The Governing Board will receive reports of the data on the bi-weekly basis.
-

Individual Responsible:
Director of Nursing
Date Completed:
5/17/2019

A 405 Item #5Plan of Correction for Each specific deficiency Cited:
The Hospital failed to follow policy by not administering medication as directed per orders and CIWA protocol by the nurse after assessed.

Procedure/process for implementing the plan of correction:

- RNs were reeducated on the proper procedures of CIWA protocol.
- A re-orientation and competency tool for documentation of CIWA protocols has been created and all nursing staff will be re-trained in documenting and updating and individualized care plan by 5/16/2019 or have completed prior to the next shift after this date if unable to attend as a group for competency.
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Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- 100% of medical records will be audited monthly for identified CIWA patients. 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.
- Reports on audits of the medical record will be reported by the CNO at the weekly survey team meeting to ensure compliance with the education.
- Nursing identified in non-compliance will be educated in a non-punitive way for additional education upon identification after the re-education.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/16/2019

A 618 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to provide the nutritional needs of the patient.

Procedure/process for implementing the plan of correction:

- The hospital's providing nutritional needs of by the nursing and the dietary staff being re-educated by the dietitian.
- Snacks are individualized by the dietary department based on allergies and placed in a separate bin with name to ensure safe delivery of day long snacks.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- 16 Individualized snack bags are randomly audited each week to ensure that snacks have appropriate items placed within. This audit will continue until 100% compliance is achieved for 3 months. If

compliance falls below 98% for two consecutive months a new corrective action plan will be created and audited until 100% compliance is reached for 3 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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/17/2019

A 620 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to provide supervision of personnel providing dietary services, and implementing policies and procedures that ensure that patients with food allergies or other special dietary needs are implemented.

Procedure/process for implementing the plan of correction:

- The Dietician was re-educated on ensuring that the position supervises dietary services on the administration of food.
- Nursing staff and dietician were reeducated on the proper procedures for screening for food allergies.
- Nurses and the Dietician were re-educated to place any allergies identified post admission to the allergies worksheet, **admission dietary communication sheet** and is forwarded to the pharmacy department for placement in the MAR, and to identify on the KARDEX.
- Snacks are individualized by the dietary department based on allergies and placed in a separate bin with name to ensure safe delivery of day long snacks.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- The dietician will audit 16 Individualized snack bags randomly each week to ensure that snacks have appropriate items placed within. This audit will continue until 100% compliance is achieved for 3 months. If compliance falls below 98% for two consecutive months a new corrective action plan will be created and audited until 100% compliance is reached for 3 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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/17/2019

A 629 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to ensure the menus met the needs of the patient.

Procedure/process for implementing the plan of correction:

- The hospital now ensures the individual patient's nutritional needs are met in accordance with recognized dietary practices.
- All nursing staff and dietician were reeducated on the proper procedures for dietary modifications.
- Snacks are individualized by the dietary department based on allergies as well as dietary restrictions and placed in a separate bin with name to ensure safe delivery of day long snacks.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- Based on dietary modifications the dietician will audit 16 Individualized snack bags randomly each week to ensure that snacks have appropriate items placed within. This audit will continue until 100% compliance is achieved for 3 months. If compliance falls below 98% for two consecutive months a new corrective action plan will be created and audited until 100% compliance is reached for 3 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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee on the monthly basis.
- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Nursing
Date Completed:
5/17/2019

A 837Plan of Correction for Each specific deficiency Cited:
The Hospital failed to ensure the patient and receiving facility receive a copy of the discharge/transfer per policy.

Procedure/process for implementing the plan of correction:

- The Director of Clinical Services re-trained departmental staff to follow policy for ensuring all patients allowing transfer of copies of discharge. This includes but is not limited to:
    - Receiving a confirmation fax document confirming receiving facility has received.
    - Above document is placed in the medical record.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- The Director of Clinical services will review 100% log of all confirmed transferred documents on a weekly basis to other facilities from patients allowing the communication of documentation.
- Above audit will continue for 3 months of 100% to assure that the process is in compliance. If the audit drops below a 90% compliance rating for 2 consecutive months a new plan of correction must be created.

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: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- Above audits will be provided to the weekly survey team meeting for report out and to the PI committee

on the monthly basis.

- The Governing Board will receive reports of the data on the bi-weekly basis.

Individual Responsible:
Director of Clinical Services
Date Completed:
5/16/2019