State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety investigation. On site dates: 11/15/22, 11/16/22, and 11/18/22 Case numbers: 2022-9864, 2022-1410, 2022-3444, and 2021-7589 Intake numbers: 124544, 120319, 120857, and 113654 The investigation was conducted by: Investigator #1 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by 12/26/22. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 340	322-035.1H PROCEDURES-BEHAVIOR WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 340		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Austin Martin | TITLE: CFO | (X6) DATE: 12/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 1 written policies and procedures consistent with this chapter and services provided: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that nursing staff assessed and documented in the medical record the status and any relevant behaviors of patients on special precautions (including Sexual Acting Out (SAO) precautions), as demonstrated by 10 of 10 medical records reviewed (Patient #1502, #1503, #1504, #1505, #1506, #1507, #1508, #1509, #1510, and #1511). Failure to ensure that nursing staff assessed and documented the patient's status and relevant behaviors of patients identified to be at an increased risk of harm to self or others puts patients at risk for delayed or inappropriate interventions and increases the risk for an unsafe environment of care. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Levels," policy number POC 100.43, last reviewed 04/21, showed the following:	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 2 a. There are specific protocols and required documentation for each observation level. b. Reasons for these levels of awareness may include but are not limited to suicide risk, homicide risk, falls risk, potential for aggressive behavior and/or potential for sexually acting out behavior. c. The nurse should address the status of the patient on special precautions in the nursing reassessment documented each shift. Document review of the hospital's policy and procedure titled, "Sexual Acting Out (SAO)/Sexual Aggression Precautions," policy number POC 100.68, last reviewed 01/22, showed the following: a. Sexual Acting Out: A patient who has a clinically relevant history of sexually acting out, inappropriate, aggressive, or predatory behavior towards the opposite sex, as indicated in the Comprehensive Nursing Assessment, Intake information, or other reports. b. The Registered Nurse (RN) ensures that an Individual treatment plan (ITP) for the Sexual Acting Out precautions is implemented. c. The RN reports the patient's behavior surrounding Sexual Acting Out precautions in the Shift Report. d. The RN documents in clinical notes each shift: i. That the patient is on SAO precautions. ii. Any pertinent patient comments regarding	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 3 sexually inappropriate behavior. iii. Any attempts to engage in sexually inappropriate behavior and outcome. iv. Staff interventions and results. 2. Investigator #1 reviewed the medical records of 10 patients (Patient #1502, #1503, #1504, #1505, #1506, #1507, #1508, #1509, #1510, and #1511) who had been identified with an increased risk of harm to self or others and placed on Sexual Acting Out (SAO) precautions. The Daily Nursing Progress notes for each shift (Day shift and Night Shift) were reviewed, taking into consideration the date the SAO precautions were initiated. The findings are as follows: a. A total of 140 Daily Nursing Progress Notes for day shift and night shift were reviewed. On 48 of 140 Progress Notes nursing staff documented the patient's clinical status or observed behaviors related to their enhanced safety precautions for SAO, as directed by hospital policy. b. 48 of 48 failed to document the patient's response to interventions, such as reminders to maintain appropriate boundaries with peers. c. The review found that for 59 of 140 Progress Notes nursing staff failed to document the patient's clinical status or observed/reported behaviors related to their enhanced safety precautions for SAO. d. On 33 of 140 Progress Notes, nursing staff documented "no issues, no behaviors, or none observed." 12 of 33 of the Progress Notes failed to document if the "issues or behaviors" were related to sexually inappropriate behaviors or	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 340	Continued From page 4 other precautions that were identified for the patients, such as self-harm or suicidal ideation. 3. Review of the medical records found that nursing staff failed to consistently document each shift any behaviors, interventions, and response to interventions for patients placed on SAO precautions. 4. On 11/17/22 at 3:45 PM, during an interview with Investigator #1, the Chief Clinical Officer (CCO) (Staff #1504) stated that if there is an ITP for enhanced safety precautions, such as SAO, staff should be documenting the patient's progress towards treatment goals. Staff #1504 stated that she was unsure if it was the nurse's responsibility to document updates for all the problems identified on the MTP Problem List. During review of the hospital's Sexual Acting Out (SAO)/Sexual Aggression Precaution Policy with Investigator #1, Staff #1504 verified that nursing staff was not always documenting the patient's status related to the enhanced precautions as directed by hospital policy.	L 340		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 5 treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff assessed the patient's progress towards treatment goals and revised the patient's treatment plans when indicated, to ensure a safe environment of care and meet the patient's individualized care needs, as demonstrated by 7 of 11 medical records reviewed (Patient #1501, #1502, #1504, #1505, #1507, #1510, and #1511. Failure to ensure that treatment plans are updated and revised to reflect the patient's progress towards individualized treatment goals puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number POC 100.90, last reviewed 04/21, showed the following: a. The Master Treatment Plan (MTP) will be developed utilizing information obtained in the	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 6 Psychiatric Evaluation, History and Physical (H&P), Psychosocial Assessment (PSA), and all other consults and assessments. b. The Therapist will transcribe all psychiatric diagnoses from the Psychiatric Evaluation onto the Master Problem List and include all identified psychiatric problems. c. The treatment team will meet and review the Master Problem List, Areas of Concern, Strengths, Stressors, Discharge Criteria, and Discharge Plan. d. Treatment Plan Review - The treatment plan will be reviewed and/or updated weekly at the treatment team meeting or when necessary due to a change in the patient's condition. The treatment plan review will reflect changes in the patient's course of treatment. e. The treatment plan review will include: i. Progress towards each psychiatric and medical problem. ii. Behavioral events. iii. Current precautions. f. The treatment team will review the treatment plan together and make necessary changes based on the patient's needs and preferences. Patient #1501 2. Patient #1501, a 17-year-old transgender (male to female) adolescent, was admitted voluntarily on 11/10/22, for a recent suicide attempt and current suicidal ideation with a plan.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 7 The Patient reported a history of sexual abuse by their adoptive mother. Review of the medical record showed the following: a. Due to the Patient's history of reported sexual abuse, on 11/10/22 staff added "Sexual Victimization Precautions (SVP)" to the MTP's Problem List and initiated an ITP. b. On 11/12/22 staff added "Lack of Impulse Control - 5-foot Rule" to the MTP's Problem List and initiated an ITP. Staff failed to document on the ITP the reasoning for the initiation of the 5-foot Rule. c. Review of the Nursing Progress Notes found that on 11/11/22, nursing staff documented that the Patient needed redirection to maintain appropriate boundaries. On the Nursing Progress Note dated 11/12/22, nursing staff documented a discussion with Patient #1501 regarding comments the Patient made about raping someone. The Patient remained on SVP precautions and the 5-foot Rule. 3. On 11/17/22 at 11:45 AM, during an interview with Investigator #1, the Mental Health Technician (Staff #1505) stated that over the weekend (11/11/22-11/12/22), Patient #1501 and 2 other adolescent patients seemed to be "clicking" and feeding off each other. One of the other patients was 13 years old and had the potential for victimization. The three patients were placed on 5-foot Rule precautions to maintain physical distance between each other and monitor touching. 4. Review of Patient #1501's Treatment Plan Update dated 11/16/22 showed the following:	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 8 a. Problem P4 - Sexual Victimization Precautions: Staff documented no reported behaviors. b. Problem P8 - 5-foot Rule: Staff failed to list this Problem on the Treatment Plan Update. Staff failed to document the Patient's progress towards treatment goals identified on the ITP. c. Staff failed to update the Treatment Plan by documenting the incident involving the two other adolescent patients that was reported over the weekend of 11/11/22-11/12/22. Patient #1502 5. Patient #1502, a 17-year-old adolescent male, was admitted voluntarily on 04/15/21, for a recent suicide attempt and current suicidal ideation. Review of the medical record showed the following: a. On 04/15/21 staff added "Sexual Acting Out" to the MTP's Problem List and initiated an ITP based on the Patient's history of sexually inappropriate behavior during their previous admission. b. Review of Patient #1502's Weekly Treatment Plan Update dated 04/22/21 showed the following: i. Staff documented that the Patient did not have any behavioral events since admission. ii. Staff failed to document the Patient's status or progress made for Psychiatric Problem #P5 - Sexual Acting Out. iii. In the section of the update intended to describe the patient's progress toward treatment	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 9	L1065		

goals, staff documented that the Patient reported "had a few problems, but they have been resolved."

iv. On an incident report dated 04/17/21, staff documented that Patient #1502 and another adolescent patient "smacked each other on the butt." Both patients were interviewed and stated that it was consensual. Staff failed to document on the Weekly Update the incident of sexually inappropriate behavior on 04/17/21.

v. No changes were made to the Patient's plan of care during the treatment plan review of 04/22/21.

c. Review of the Weekly Treatment Plan Update dated 04/29/21 showed the following:

i. Staff documented that Patient #1502 was making "Adequate/Significant Progress" with Problem #P5 Sexual Acting Out.

ii. Staff failed to fill out the section of the update documenting any behavioral events since admission or last update, leaving it blank.

iii. In the section of the update intended to describe the patient's progress toward treatment goals, staff document that the Patient appears to have proper boundaries.

iv. On an incident report dated 04/27/21, staff documented that Patient #1502 was unable to maintain boundaries with female peers. Staff failed to include documentation of the incident of sexually inappropriate behavior on 04/27/21.

v. No changes were made to the Patient's plan of care during the treatment plan review of 04/29/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 10 d. Review of the Weekly Treatment Plan Update dated 05/13/21 showed the following: i. Staff documented that Patient #1502 was making "None/Some/Minimal Progress" with Problem #P5 Sexual Acting Out. ii. In the section of the update documenting any behavioral events since admission or last update, staff documented that the Patient did not have any behavioral events since admission. iii. In the section of the update intended to describe the patient's progress toward treatment goals, staff documented that the Patient stated, "not at all." iv. Staff failed to include documentation from the Nursing Progress Notes on 05/06/21 and 05/10/21 when staff observed the Patient's sexually inappropriate behavior, including "flirting, inappropriate sexual behavior and sexual statements." v. No changes were made to the Patient's plan of care during the treatment plan review of 05/13/21. e. Review of the Weekly Treatment Plan Update dated 05/19/21 showed the following: i. Staff documented that Patient #1502 was making "Adequate/Significant Progress" with Problem #P5 Sexual Acting Out. ii. Staff failed to fill out the section of the update documenting any behavioral events since admission or last update, leaving it blank. iii. In the section of the update intended to describe the patient's progress toward treatment	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 11	L1065		

goals, staff documented that the Patient "denied" any behaviors.

iv. Staff failed to include documentation of the incident of sexually inappropriate behavior on 05/13/21 when Patient #1502 followed a female peer into her room. Staff found the two patients later emerging from the bathroom. Both patients denied that any physical touch occurred.

v. No changes were made to the Patient's plan of care during the treatment plan review of 05/19/21.

Patient #1504

6. Patient #1504, a 16-year-old female adolescent, was admitted involuntarily on 04/23/21, due to Suicidal Ideation with a recent suicide attempt. Review of the medical record showed the following:

a. Due to the Patient's reported history of sexual assault, staff added "Sexual Victimization Precautions (SVP)" to the MTP's Problem List and initiated an ITP dated 04/23/21.

b. On 04/25/21 staff added "Sexual Acting Out (SAO)" to the MTP's Problem List and initiated an ITP based on the Patient's reported sexually inappropriate behavior.

c. Review of the Weekly Treatment Plan Update dated 04/30/21 showed the following:

i. Staff documented that Patient #1504 was making "Adequate/Significant Progress" with Problem #P2 Sexual Victimization and Problem #P7 Sexual Acting Out.

ii. Staff failed to fill out the section of the update

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 12 documenting any behavioral events since admission or last update, leaving it blank. iii. In the section of the update intended to describe the patient's progress toward treatment goals, staff failed to document a description of the Patient's progress for Problems #P2 and #P7, leaving the identified problems blank. iv. Staff failed to include nursing documentation that reported observations of sexually acting out behaviors. v. No changes were made to the Patient's plan of care during the treatment plan review of 04/30/21. d. Review of the Weekly Treatment Plan Update dated 05/07/21 showed the following: i. Staff documented that Patient #1504 was making "Adequate/Significant Progress" with Problem #P2 Sexual Victimization and "None/Minimal/Some Progress" with Problem #P7 Sexual Acting Out. ii. Staff failed to fill out the section of the update documenting any behavioral events since admission or last update, leaving it blank. iii. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P2 - SVP, staff documented that the "patient did not report any triggers." iv. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P7 - SAO, staff documented that the "patient has continued to portray behavior of sexual aggression." v. The Weekly Update failed to include	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 13	L1065		

documentation of the incident report dated 05/05/21, when Patient #1504 and a male peer were found touching each other's genitals.

vi. Staff failed to include nursing documentation that reported observations of sexually inappropriate behaviors for 6 of 7 days from 05/01/21 through 05/07/21.

vii. No changes were made to the Patient's plan of care during the treatment plan review of 05/07/21.

e. Review of the Weekly Treatment Plan Update dated 05/14/21 showed the following:

i. Staff documented that Patient #1504 was making "Adequate Progress" with Problem #P2 Sexual Victimization and Problem #P7 Sexual Acting Out.

ii. Staff document that Patient #1504 had had no behavioral events since admission or last update.

iii. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P2 - SVP and Problem #P7 - SAO, staff documented that the patient had "appropriate boundaries."

vi. Staff failed to include nursing documentation of continued sexually inappropriate behavior that included reported observations of "hypersexual behaviors" on 05/09/21 and "hugged a peer and talked sex" on 05/10/21.

v. No changes were made to the Patient's plan of care during the treatment plan review of 05/14/21.

f. Review of the Weekly Treatment Plan Update

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 14 dated 05/21/21 showed the following: i. Staff documented that Patient #1504 was making "Adequate/Significant Progress" with Problem #P2 Sexual Victimization and Problem #P7 Sexual Acting Out. ii. Staff documented that Patient #1504 had had no behavioral events since admission or last update. iii. In the section of the update intended to describe the patient's progress toward treatment goals, staff failed to document a description of the Patient's progress for Problems #P2 and #P7, leaving the identified problems blank. vi. Staff failed to include nursing documentation of continued sexually inappropriate behavior that included reported observations of inappropriate behaviors with peers, including "cat calls" on 05/15/21, inappropriate behavior and sexual remarks on 05/16/21, writing notes to a peer that were "sexual in nature" on 05/17/21, and sexually preoccupied behavior on 05/18/21. v. No changes were made to the Patient's plan of care during the treatment plan review of 05/21/21. Patient #1505 7. Patient #1505, a 15-year-old male adolescent, was admitted voluntarily on 01/19/22, due to Suicidal Ideation with a plan. Review of the medical record showed the following: a. On 01/22/22 staff added "Sexual Acting Out (SAO)" to the MTP's Problem List and initiated an ITP based on the Patient's recent reported incident on 01/21/22 when Patient #1505 allowed	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 15 a peer to touch his thigh, then both patients engaged in mutual touching of their genitals over their clothing. b. Review of the Weekly Treatment Plan Update dated 01/26/22 showed the following: i. Staff documented that Patient #1505 was making "Adequate/Significant Progress" with Problem #P10 Sexual Acting Out. ii. Staff documented in the response to the question if any behavioral events have occurred since admission or last update that the Patient was "consistently defiant and oppositional," however failed to note the reported incident sexually inappropriate behavior on 01/21/22. iii. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P10 - SAO, staff documented that the patient denied any incidents of sexual acting out. iv. The Weekly Update failed to include documentation of an additional sexually inappropriate incident that took place on 01/23/22, when Patient #1505 touched a female patient's upper left thigh in a sexually inappropriate manner. v. Staff failed to include nursing documentation of continued sexually inappropriate behavior that included reported observations of inappropriate behaviors on 01/21/22, sexually inappropriate incidents involving two female peers on 01/22/22 and 01/23/22, and repeated reminders to maintain appropriate boundaries and maintain the 5-foot rule on 01/24/22.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 16 vi. No changes were made to the Patient's plan of care during the treatment plan review of 01/26/22. Patient #1507 8. Patient #1507, a 15-year-old male adolescent, was admitted voluntarily on 10/14/22, due to Suicidal Ideation with command auditory hallucinations. Review of the medical record showed the following: a. Due to the Patient's reported history of sexual abuse, staff added "Sexual Victimization Precautions (SVP)" to the MTP's Problem List and initiated an ITP dated 10/14/22. b. On 10/20/22 staff added "Sexual Acting Out (SAO)" to the MTP's Problem List and initiated an ITP based on the Patient's recent reported incident on 10/19/22 when Patient #1507 rubbed another patient's leg and stated that he would like to engage in sex and take him on a date. c. Review of the Weekly Treatment Plan Update dated 10/21/22 showed the following: i. Staff documented that Patient #1507 was making "None/Minimal Progress" with Problem #P5 Sexual Victimization and Problem #P6 Sexual Acting Out. ii. Staff documented that Patient #1507 had no behavioral events since admission or last update. iii. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P5 - SVP, staff documented that the patient had "no victimization." iv. In the section of the update intended to	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 17	L1065		

describe the patient's progress toward treatment goals for Problem #P6 - SAO, staff documented "no report of acting out."

v. The Weekly Update failed to include documentation of the sexually inappropriate incident reported on 10/19/22.

vi. No changes were made to the Patient's plan of care during the treatment plan review of 10/21/22.

Patient #1510

9. Patient #1510, a 13-year-old female adolescent, was admitted voluntarily on 01/05/22, due to Suicidal Ideation with a plan and recent suicide attempts. Review of the medical record showed the following:

a. On the Daily Nursing Note dated 01/05/22 at 1:00 PM, nursing staff documented that Patient #1510 was placed on SAO precautions and a 5-foot Rule due to "having a peer's feet in her lap."

b. Review of the MTP Problem List found that staff added Psychiatric Problem #P3 Sexual Acting Out. The Patient's medical records failed to contain an ITP for the identified problem.

c. Review of the Weekly Treatment Plan Update dated 01/12/22 showed the following:

i. Staff documented that Patient #1510 was making "None/Minimal Progress" with Problem #P3 Sexual Acting Out.

ii. Staff documented that Patient #1510 had no behavioral events since admission or last update.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 18 iii. In the section of the update intended to describe the patient's progress toward treatment goals for Problem #P3 - SAO, staff documented "boundaries are maintained with occasional reminders." iv. The Weekly Update failed to include documentation of the sexually inappropriate incident reported on 01/05/22. v. Staff failed to include nursing documentation of continued sexually inappropriate behavior and difficulty maintaining physical boundaries for 3 of 6 Daily Nursing Progress Notes reviewed (01/06/22, 01/08/22, and 01/12/22). vi. No changes were made to the Patient's plan of care during the treatment plan review of 01/12/22. Patient #1511 10. Patient #1511, a 16-year-old transgender (male to female) adolescent, was admitted voluntarily on 11/12/22, due to Suicidal Ideation with a recent suicide attempt. Review of the medical record showed the following: a. On 11/12/22 staff added 5-foot Rule to the Psychiatric Problems List on the MTP and initiated an ITP for Impulsive Behavior - 5-foot Rule Restriction. The ITP failed to contain a long-term goal or list any interventions for nursing staff. b. On the Daily Nursing Progress note dated 11/13/22, staff documented that the Patient was not sticking to the SAO precautions or the 5-foot Rule. The Patient had to be reminded several times to stay away from 13- and 14-year-old peers.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013134	A. BUILDING: _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 19	L1065		

c. On 11/14/22 the psychiatric provider wrote an order to add SAO precautions due to the Patient "being a predator to 13- and 14-year-old girls."

d. Review of the Patient's treatment planning documents showed that staff failed to initiate an ITP for SAO, or create a plan of care, treatment goals, identify interventions, and monitor the Patient's progress towards the treatment goals.

11. On 11/17/22 at 11:15 AM, during an interview with Investigator #1, the Registered Nurse (RN) (Staff #1504) stated that if patients are involved in any sexual incidents or sexually inappropriate language, they should be on SAO precautions. The charge nurses will provide the treatment team with updates on the patient's behavior and progress towards treatment goals with these precautions.

12. On 11/17/22 at 3:00 PM, during an interview with Investigator #1, the Chief Clinical Officer (CCO) (Staff #1504) reviewed the incident reports (from 05/21 and 01/22 to present). Staff #1504 stated that on the incident reports reviewed, staff documented that the treatment plans had been reviewed and updated. Staff #1504 verified that the treatment plan updates and individual treatment plans for Patients #1502, #1504, #1505, and #1507 failed to include documentation of the documented sexually inappropriate incidents or recommendations for revisions to the treatment plan.

POC Recd 01.04.23
POC Approved 01.11.23
Mary Newtmsn, RN
DOH

Smokey Point Behavioral Health

Plan of Correction for
State Investigation #2022-9864, #2022-1410, 2022-3444, and #2022-7589
Exit 11/18/22

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L340	1) Re-education of the following policies "Observation Levels" policy #100.43 and "Sexual Acting Out (SAO) policy #100.68 is being completed with all nursing staff who are required to sign an attestation verifying understanding of documentation requirements per policies listed here. a. Complete an assessment of SAO behaviors including triggers each shift b. Document each shift in notes patient assessment, relevant behaviors and progress toward goals, interventions used or changed 2) Education on the Observation Levels policy and Sexual Acting Out (SAO) policy is being added to new hire orientation. a. Education provided in both New Hire Orientation and Re-education will cover/highlight expectations regarding documentation procedures and standards in Treatment Planning and Daily Nursing Notes.	Chief Clinical Officer	Education will be completed for all nursing staff by 1/17/23 or their next scheduled shift.	1) Audits are being completed for 100% of patients on SAO precautions, by the Chief Clinical Officer or designee monthly to verify that documentation is being completed in the treatment plan and in the progress notes per policy guidelines. Data that is being audited includes Daily notes which include assessment of precautions, behaviors, specific SAO incidents, Patient's precaution status, interventions and response to intervention(s). Audits will continue monthly until 95% compliance is achieved for three consecutive months, then random audits will continue for sustained compliance. If documentation is found to not be completed per policy guidelines, the Chief Clinical Officer or designee will document follow up with the involved nursing staff of corrective actions taken as

				indicated and documentation of failures secondary to any identified processes will be identified. Recommendations will be made at that time and included in progress reports. 2) Outcomes of monthly audits will be reported in the Quality/ PI, Med Exec and Governing Board committee meetings.
L 1065	1) "Treatment Planning" policy #100.90 was reviewed and it was determined that no revisions were needed. 2) Education on the treatment plan process and documentation requirements is being completed with nursing staff, clinical staff and providers to address initial implementation of SAO and/or SVP precautions if indicated, documentation of events if they occur since admission or last seen, progress or lack of progress toward each psychiatric and medical problem and process for treatment team review to discuss patient changes and individual needs and preferences. Staff and providers are required to sign an attestation verifying understanding of the treatment team process and documentation requirements per policies listed here. a. This education focus includes the expectation and requirement that existing SAO Treatment Plans will be updated following any change in a patient behaviors noted during daily assessments. Staff will be trained to initiate a Treatment Plan Update, immediately following the incident. Any Nurse, Therapist or Provider can initiate an update. On Mondays, Wednesdays and Fridays, the Multidisciplinary Team conducts Treatment Plan reviews, to ensure Treatment Plans are updated appropriately, based on Patient's recent Incidents.	Chief Clinical Officer	Education will be completed for all nursing staff, clinical staff and providers by 1/17/23 or their next scheduled shift.	1) Audits are being completed for 100% of patients on SAO/SVP precautions, by the Chief Clinical Officer or designee monthly to verify that documentation is being completed in the treatment plan and in the progress notes per policy guidelines. Treatment Plan audits will be focus on the congruency of documented behaviors and meeting the expectation that behaviors and / or intervention responses / changes to interventions will be updated in the weekly treatment plan. Audits on 100% of Patients on SAO/SVP will continue until 95% compliance is achieved for three consecutive months, then random audits will continue for sustained compliance. If documentation is found to not be completed per policy guidelines, the Chief Clinical Officer or designee will document follow up with the involved nursing staff of corrective actions taken as

	b. The expectation reviewed during education includes the requirement that the person / discipline documenting behaviors daily must also update the treatment plan at that time so that when reviewed weekly, any changes can be reviewed by the team. 3) Education provided in Re-education is being used to update and improve education included in the New Hire Orientation.			indicated and documentation of failures secondary to any identified processes will be identified. Recommendations by CCO or designee will be made to Staff member, regarding documentation improvements. 2) Outcomes of monthly audits will be reported in the Quality/ PI, Med Exec and Governing Board committee meetings. Information/Data regarding Staff follow-up will be included in Progress Reports.

PR Rec'd 03/15/23
Approved 03/22/23
Mary Drew MSN, RN
DOH

PROGRESS REPORT REVIEW
Cases #2022-9864, 2022-1410, 2022-3444, and 2022-7589 (KUHE11)
Exit: 11/18/22
Revision Rec'd 03/07/23 Reviewed 03/13/23
Revision Rec'd: 03/15/2023

<table>
<tr><th>TAG</th><th>How Corrected:</th><th>Monitoring Results-Questions:</th></tr>
<tr><td>L340</td><td>Nursing Documentation Requirements for Patients on special precautions (including SVP and SAO)

Per Approved Plan of Correction, audits completed for 100% of patients on SAO and SVP precautions – Nursing Documentation.

Data monitored via Audit includes:
• Verification that patient in on appropriate precautions (SAO/SVP) through Observation Sheets
• Daily Nursing Notes for inclusion of information regarding progress, new events/behaviors or regression.
• Treatment Planning Documentation (Master Treatment Plan, Problem Pages & Treatment Plan Review/Update)
• Incident Reports

Audits for Tag L340 & Tag L1065 were conducted at the same time, due to overlap in Documentation and area of interest audited.</td><td>AUDIT DATA RESULTS
<table>
<tr><th>Documentation Audit</th><th>JAN</th><th>FEB</th><th>MAR</th></tr>
<tr><td>Appropriate Precautions</td><td>27 of 27 charts reviewed = 100%</td><td>31 of 31 charts reviewed = 100%</td><td>25 of 25 charts reviewed = 100%</td></tr>
<tr><td>Behaviors/ Incidents</td><td>27 of 27 charts reviewed = 100%</td><td>30 of 31 charts reviewed = 97%</td><td>25 of 25 charts reviewed = 100%</td></tr>
<tr><td>Daily Notes for inclusion of information regarding progress, new events/behaviors or regression.</td><td>26 of 27 charts reviewed = 96%</td><td>28 of 31 charts reviewed = 90%</td><td>25 of 25 charts reviewed = 100%</td></tr>
<tr><td>Treatment Planning</td><td>24 of 27 charts reviewed = 88%</td><td>31 of 31 charts reviewed = 100%</td><td>25 of 25 charts reviewed = 100%</td></tr>
</table>
STAFF EDUCATION RESULTS
Staff are not permitted to resume their assigned shift, until completion of education and attestation. CNO has provided a print out of Names of Staff members assigned to complete training, at the beginning of their next shift, in which the Nurse Supervisor meets with each Staff member upon their return to work, to provide education, Attestation and clarify any questions/concerns. CNO or Designee will continue to monitor Staff returning to shift for completion of education, at their shift return.

As of 02/17/2023, 8 of 8 Providers were trained.
As of 02/17/23, 103 of 244 clinical and nursing staff were trained.
As of 03/15/23, 180 of 244 clinical and nursing staff were trained.</td></tr>
<tr><td>L1065</td><td>Required Documentation for Treatment Planning/Updates

Per Approved Plan of Correction, audits completed for 100% of patients on SAO and SVP precautions-Treatment Planning/Updates Documentation.</td><td>AUDIT DATA RESULTS
<table>
<tr><th>Documentation Audit</th><th>JAN</th><th>FEB</th><th>MAR</th></tr>
<tr><td>Appropriate Precautions</td><td>27 of 27 charts reviewed = 100%</td><td>31 of 31 charts reviewed = 100%</td><td>25 of 25 charts reviewed = 100%</td></tr>
<tr><td>Behaviors/ Incidents</td><td>27 of 27 charts reviewed = 100%</td><td>30 of 31 charts reviewed = 97%</td><td>25 of 25 charts reviewed = 100%</td></tr>
</table></td></tr>
</table>

Data monitored via Audit includes:

- Verification that patient in on appropriate precautions (SAO/SVP) through Observation Sheets
- Daily Notes for inclusion of information regarding progress, new events/behaviors or regression.
- Treatment Planning Documentation (Master Treatment Plan, Problem Pages & Treatment Plan Review/Update)
- Incident Reports

Audits for Tag L340 & Tag L1065 were conducted at the same time, due to overlap in Documentation and area of interest audited.

Daily Notes for inclusion of information regarding progress, new events/behaviors or regression.	**26 of 27 charts reviewed = 96%**	**28 of 31 charts reviewed = 90%**	**25 of 25 charts reviewed = 100%**
Treatment Planning	**24 of 27 charts reviewed = 88%**	**31 of 31 charts reviewed = 100%**	**25 of 25 charts reviewed = 100%**

STAFF EDUCATION RESULTS

Staff are not permitted to resume their assigned shift, until completion of education and attestation. CNO has provided a print out of Names of Staff members assigned to complete training, at the beginning of their next shift, in which the Nurse Supervisor meets with each Staff member upon their return to work, to provide education, Attestation and clarify any questions/concerns. CNO or Designee will continue to monitor Staff returning to shift for completion of education, at their shift return.

As of 02/17/2023, 8 of 8 Providers were trained.
As of 02/17/23, 103 of 244 clinical and nursing staff were trained.
As of 03/15/23, 180 of 244 clinical and nursing staff were trained.