State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: _____ B. WING _____	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SOUND BEHAVIORAL HOSPITAL	605 WOODLAND SQUARE LOOP SE LACEY, WA 98503

(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), 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation. On-site dates: 01/05/23, 01/06/23 Case number: 2021-13770 Intake number: 117574 Investigation was conducted by investigator #19 There were violations found pertinent to this complaint.	L 000		
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by:	L 355		

CEO

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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L 355	Continued From page 1 Based on interview, record review, and review of policies and procedures, the hospital failed to implement policies and procedures for staff actions upon a serious change of condition as demonstrated by record review of 6 of 6 patients who were transferred to an acute care hospital after identification of a serious change of condition (Patients #1901, 1902, 1903, 1904, 1905, and 1906). Failure to ensure policies and procedures defining staff actions upon a serious change of condition are followed may result in lack of services for patients in need, exacerbation of condition, and death. Findings included: 1. Document review of the hospital's policy titled, "Nursing Assessment and Reassessment," #PC007, last revised 01/22, showed that, for those patients identified to have a physical complaint such as the flu, bleeding, a wound, or other physical condition warranting closer assessment, the nurse will reassess the patient every hour to monitor for worsening condition until improvement is identified. Patient #1901 2. Patient #1901 was a 34-year-old man admitted on 11/02/21 for alcohol detox and suicidal ideation. An Admission Nursing Assessment, dated 11/02/21, showed that he reported a history of secondary skin infections related to chronic eczema, including a prior severe Methicillin-Resistant Staph Aureus (MRSA) infection that required intravenous Vancomycin, a broad-spectrum antibiotic. He was transferred to	L 355	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on 02/03/23. 4. Return the ORIGINAL REPORT via email with the required signatures.	

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L 356	Continued From page 2 an Emergency Department (ED) on 11/08/21 due to a change of condition in which his skin condition was noted to have exacerbated and he had an accompanying fever. He was subsequently admitted to the acute care hospital and discharged from the psychiatric hospital. A Psychiatric Note, dated 11/07/21, showed that his skin condition was noted as worsening since admission. A provider consult note, dated 11/07/21, showed that the patient had painful lesions around his wrists that extended to his elbows as well as the back of his neck, ears, and scalp, and that the episode began at the end of the previous week. The order to transfer to acute care was dated 11/07/21 at 3:33 PM. Electronic records of vital signs and assessments showed that vitals were obtained on 11/07/21 at 3:52 PM and showed that the patient had a temperature of 101.7 degrees Fahrenheit. One more set of vitals on 11/07/21 was obtained at 8:40 PM showing a temperature of 101.1. The Memorandum of Transfer (MOT) showed an additional set of vital signs taken at 3:00 PM on 11/07/21. No additional skin assessments were documented between the order for transfer and the transfer. The patient left the hospital on 11/08/21 at 12:15 AM. Patient #1902 3. Patient #1902 was a 56-year-old man admitted on 12/20/22 for Major Depressive Disorder and Alcohol Use Disorder. An Admission Nursing Assessment, dated 12/20/22, showed that the patient had pain, swelling, and redness on his toes that was noted upon admission. The patient had a radiology consultation on 12/22/22 at 6:54 PM; the consult showed the patient had osteomyelitis. An order, dated 12/30/22 at 4:43 PM, was given to transfer the patient to the ED for further evaluation. A nurse's note, dated	L 355		

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L 355	Continued From page 3 12/31/22 at 6:00 AM, showed that the patient refused transfer once transportation arrived at the hospital. A second transfer order was obtained, dated 12/31/22 at 6:52 PM. The MOT showed the patient transferred to the hospital on 12/31/22 at 7:00 PM with an additional set of vital signs documented on the MOT for that time. Electronic records showed that vital signs obtained between the initial order for transfer and the transfer were taken as follows: on 12/30/22, vital signs were obtained at 7:44 PM. On 12/31/22, vital signs were obtained at 12:26 PM, 3:30 PM, and 7:11 PM. Patient #1903 4. Patient #1903 was a 59-year-old woman admitted on 11/06/21 for alcohol detox. A nurse's note, dated 11/09/21, showed the patient presented with fatigue, weakness, and an unsteady gait and required assistance to ambulate to the restroom. A clinician note, dated 11/10/21 at 2:00 PM, showed that during an attempt to perform a clinical assessment, the patient had to be returned to her room and put back in bed because she could "hardly talk." A nurse's note, dated 11/11/21 at 7:00 PM, showed that the patient continued to appear to decline. A provider's order to transfer her to the ED was obtained on 11/11/21 at 1:00 PM. A provider's note showed that the patient went to the ED with hepatic encephalopathy. The Emergency Transfer Return Note, dated 11/12/21 at 9:00 AM, showed that she had a diagnosis of possible liver failure. The patient had vital signs assessed on 11/10/21 at 7:59 AM, 11:58 AM, 4:39 PM, and 8:20 PM. Vital signs obtained on 11/11/21 were as follows: 12:10 AM, 4:01 AM, and 8:39 AM. She was transferred to the ED at 12:45 PM on 11/11/21; an additional set of vital signs were	L 355		

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L 355	Continued From page 4 documented at that time. Patient #1904 5. Patient #1904 was a 49-year-old woman admitted on 12/21/22 for suicidal ideation. A nurse's note, dated 12/23/22 at 11:30 PM, after the transfer occurred, showed she presented with chest pain on 12/23/22. No time for the report of chest pain was given. She received one dose of nitroglycerin at 9:45 PM without relief. An order to transfer to the ED was obtained at 10:15 PM, and she left at 10:22 PM on 12/23/22. Review of electronic records showed that only one set of vital signs were obtained on 12/23/22 after the pain was reported; those were taken at 9:07 PM. The MOT reflected an additional set of vital signs obtained at 9:45 PM. Patient #1905 6. Patient #1905 was a 25-year-old man admitted on 11/02/21 for Major Depressive Disorder, Schizophrenia, and Alcohol Use Disorder. Records showed that he had a wound assessed in a consult with a medical provider on 11/04/21 at 1:20 PM. He was transferred to the ED at 3:30 PM on 11/04/21. Electronic records showed no vital signs obtained in the time period between the consult and the transfer. A set of vitals were reflected on the MOT with no time documented. Vital signs obtained on 11/04/21 were at 8:04 AM and 9:26 PM. No other assessment is documented. Patient #1906 7. Patient #1906 was a 33-year-old woman admitted on 12/30/22 for opioid use. An order was obtained on 12/31/22 at 2:34 PM to transfer	L 355		

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L 355	Continued From page 5	L 355		

her "as soon as possible" for likely abscess with phlebitis. MOT, dated 12/31/22, showed that transportation was requested at 4:16 PM and had an estimated time of arrival of 11:00 PM. The MOT and nurse's notes did not reflect the time of departure. The MOT showed vital signs noted as "at time of departure" were obtained at 4:16 PM; the acceptance for transfer from the ED was at 9:00 PM. The Incident Report showed that the patient had an order to go to the ED but also did not reflect time of departure. On 12/31/22, electronic records showed that vital signs were documented for 3:07 AM, 7:45 AM, 2:01 PM, and 7:08 PM. No other assessments were documented from the time the wound was assessed for worsening symptoms until transfer.

8. On 01/06/23 at 1:15 PM, Investigator #19 interviewed Staff #1906, staff Registered Nurse (RN), regarding the procedure followed by staff when a change of condition is identified. When asked about assessments after a change of condition is identified, she stated that the nurse would assess as per the existing order from the provider unless it was an emergency. She stated that the nurse would use their best judgment to decide if vital signs should be done more often than the order directs in the case of an emergency. She said the frequency of vital signs, even in the case of a medical transfer, would be determined on a case-by-case basis.

9. On 01/06/23 at 1:30 PM, Investigator #19 interviewed Staff #1907, staff RN, regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with Staff #1906, specifically that the frequency of assessments and vital signs were determined on a case-by-case basis in the event of a change of condition, including any change

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L 355	Continued From page 6	L 355		

requiring transfer to the ED. He stated that the nurse would follow the original order, usually to take vital signs every 4 hours or each shift, and may decide to do them more frequently per the nurse's judgment.

10. On 01/06/23 at 2:00 PM, Investigator #19 interviewed Staff #1904, staff RN, regarding the procedure followed by staff when a change on condition is identified. His answer was in congruence with Staff #1906 and #1907. He stated that the frequency of assessments was determined by the provider's original order except in the case where the RN determines they need additional assessments. He stated that he repeats vital signs at the one hour mark after the identification of a change of condition, but after that frequency is determined on a case-by-case basis. He stated that he would call the doctor if he identified a further change of condition during the time they are waiting for transportation to the ED.

11. On 01/06/23 at 2:45 PM, Investigator #19 interviewed Staff #1902, Chief Nursing Officer (CNO), regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with the staff nurse responses, stating that the frequency of assessments and vital signs was determined by the provider's order and, if determined to be needed more frequently by the RN, would be on a case-by-case basis. He said that there is no minimal timeframe for assessment frequency, including in the case of a change of condition requiring transfer to an ED.

South Sound Behavioral Hospital

Plan of Correction for
State Investigation
(Case #2021-13770)

rec'd 3/20/23
approved 3/20/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L355 322-035.1K **POLICIES-STAFF ACTIONS** AC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of policies and procedures, the hospital failed to implement policies and procedures for staff actions upon a serious change of condition as demonstrated by record review of 6 of 6 patients who were transferred to an acute care hospital after identification of a serious change of condition (Patients #1901, 1902, 1903, 1904, 1905, and 1906). Failure to ensure policies and procedures defining staff actions upon a serious change of condition are followed may result in lack of services for patients in need, exacerbation of condition, and death	After this case investigation, a process review was conducted by the medical staff and nursing leadership and the following plan of correction has been/will be made: 1. PC 007: Nursing Assessment and Reassessment has been revised to ensure consistency with practice and what is written on the policy. This was submitted to the committee of the whole (Quality and Med Exec) for approval. a. Section 3.i was revised and states "If a patient is identified to have a physical complaint that warrants closer assessment, the nurse will reassess per provider's order"	CNO	2/9/2023	Approved revised policy and procedure

	• This is checking to see if there is a providers order for reassessment frequency and ensure it was follow by the staff • The re-assessment order will cover the time between the patient is waiting to be transfer to a higher level of care. 2. All (100%) of active nursing staff and All providers will be trained on the revised policy and procedure for assessment and reassessment by February 28, 2023. A chart audit of all MOT will be conducted by the nurse managers highlighting on the reassessment order/timeframe on a monthly basis and a threshold of 100% in 3 consecutive months. a) The provider is expected to tell the nurse how often would they like vitals on the patient after receiving the order to send the pt out b) If the provider do not write orders the expectation would be that the nurse takes vitals before calling the provider to assess the situation and depending on the condition that would determine the frequency. Standing orders for assessments and vitals are once every shift.	CMO and CNO	2/28/2023	• All (active nurses) (monitored through an attestation. • We audit that the MOT paperwork is completely fill out, The orders from that provider if given where follow and documented, making sure the right mode of transportation was follow. • All MOT's audited daily by nurse manager
Findings included: 1. Document review of the hospital's policy titled, "Nursing Assessment and Reassessment," #PC007, last revised 01/22, showed that, for those patients identified to have a physical complaint such as the flu, bleeding, a wound, or other physical condition warranting closer assessment, the nurse will reassess the patient				

every hour to monitor for worsening condition until improvement is identified. Patient #1901 2. Patient #1901 was a 34-year-old man admitted on 11/02/21 for alcohol detox and suicidal ideation. An Admission Nursing Assessment, dated 11/02/21, showed that he reported a history of secondary skin infections related to chronic eczema, including a prior severe Methicillin-Resistant Staph Aureus (MRSA) infection that required intravenous Vancomycin, a broad-spectrum antibiotic. He was transferred to an Emergency Department (ED) on 11/08/21 due to a change of condition in which his skin condition was noted to have exacerbated and he had an accompanying fever. He was subsequently admitted to the acute care hospital and discharged from the psychiatric hospital. A Psychiatric Note, dated 11/07/21, showed that his skin condition was noted as worsening since admission. A provider consult note, dated 11/07/21, showed that the patient had painful lesions around his wrists that extended to his elbows as well as the back of his neck, ears, and scalp, and that the episode began at the end of the previous week. The order to transfer to acute care was dated 11/07/21 at 3:33 PM. Electronic records of vital signs and assessments showed that vitals were obtained on 11/07/21 at 3:52 PM and showed that the patient had a temperature of 101.7 degrees Fahrenheit. One more set of vitals on 11/07/21 was obtained at 8:40 PM showing a temperature of 101.1. The Memorandum of				

Transfer (MOT) showed an additional set of vital signs taken at 3:00 PM on 11/07/21. No additional skin assessments were documented between the order for transfer and the transfer. The patient left the hospital on 11/08/21 at 12:15 AM. Patient #1902 3. Patient #1902 was a 56-year-old man admitted on 12/20/22 for Major Depressive Disorder and Alcohol Use Disorder. An Admission Nursing Assessment, dated 12/20/22, showed that the patient had pain, swelling, and redness on his toes that was noted upon admission. The patient had a radiology consultation on 12/22/22 at 6:54 PM; the consult showed the patient had osteomyelitis. An order, dated 12/30/22 at 4:43 PM, was given to transfer the patient to the ED for further evaluation. A nurse's note, dated 12/31/22 at 6:00 AM, showed that the patient refused transfer once transportation arrived at the hospital. A second transfer order was obtained, dated 12/31/22 at 6:52 PM. The MOT showed the patient transferred to the hospital on 12/31/22 at 7:00 PM with an additional set of vital signs documented on the MOT for that time. Electronic records showed that vital signs obtained between the initial order for transfer and the transfer were taken as follows: on 12/30/22, vital signs were obtained at 7:44 PM. On 12/31/22, vital signs were obtained at 12:26 PM, 3:30 PM, and 7:11 PM Patient #1903 4. Patient #1903 was a 59-year-old woman admitted on 11/06/21 for alcohol detox. A nurse's note, dated 11/09/21, showed the patient presented with fatigue, weakness, and an unsteady gait and required assistance to ambulate to the				

restroom. A clinician note, dated 11/10/21 at 2:00 PM, showed that during an attempt to perform a clinical assessment, the patient had to be returned to her room and put back in bed because she could "hardly talk." A nurse's note, dated 11/11/21 at 7:00 PM, showed that the patient continued to appear to decline. A provider's order to transfer her to the ED was obtained on 11/11/21 at 1:00 PM. A provider's note showed that the patient went to the ED with hepatic encephalopathy. The Emergency Transfer Return Note, dated 11/12/21 at 9:00 AM, showed that she had a diagnosis of possible liver failure. The patient had vital signs assessed on 11/10/21 at 7:59 AM, 11:58 AM, 4:39 PM, and 8:20 PM. Vital signs obtained on 11/11/21 were as follows: 12:10 AM, 4:01 AM, and 8:39 AM. She was transferred to the ED at 12:45 PM on 11/11/21; an additional set of vital signs were Patient #1904 5. Patient #1904 was a 49-year-old woman admitted on 12/21/22 for suicidal ideation. A nurse's note, dated 12/23/22 at 11:30 PM, after the transfer occurred, showed she presented with chest pain on 12/23/22. No time for the report of chest pain was given. She received one dose of nitroglycerin at 9:45 PM without relief. An order to transfer to the ED was obtained at 10:15 PM, and she left at 10:22 PM on 12/23/22. Review of electronic records showed that only one set of vital signs were obtained on 12/23/22 after the pain was reported; those were taken at 9:07 PM. The MOT reflected an additional set of vital signs obtained at 9:45 PM. Patient #1905 6. Patient #1905 was a 25-year-old man admitted on 11/02/21 for Major Depressive				

Disorder, Schizophrenia, and Alcohol Use Disorder. Records showed that he had a wound assessed in a consult with a medical provider on 11/04/21 at 1:20 PM. He was transferred to the ED at 3:30 PM on 11/04/21. Electronic records showed no vital signs obtained in the time period between the consult and the transfer. A set of vitals were reflected on the MOT with no time documented. Vital signs obtained on 11/04/21 were at 8:04 AM and 9:26 PM. NNo other assessment is documented. Patient #1906 7. Patient #1906 was a 33-year-old woman admitted on 12/30/22 for opioid use. An order was obtained on 12/31/22 at 2:34 PM to transfer her "as soon as possible" for likely abscess with phlebitis. MOT, dated 12/31/22, showed that transportation was requested at 4:16 PM and had an estimated time of arrival of 11:00 PM. The MOT and nurse's notes did not reflect the time of departure. The MOT showed vital signs noted as "at time of departure" were obtained at 4:16 PM; the acceptance for transfer from the ED was at 9:00 PM. The Incident Report showed that the patient had an order to go to the ED but also did not reflect time of departure. On 12/31/22, electronic records showed that vital signs were documented for 3:07 AM, 7:45 AM, 2:01 PM, and 7:08 PM. No other assessments were documented from the time the wound was assessed for worsening symptoms until transfer. 8. On 01/06/23 at 1:15 PM, Investigator #19 interviewed Staff #1906, staff Registered Nurse (RN), regarding the procedure followed by staff when a change of condition is identified. When asked about assessments after a change of condition is identified, she				

stated that the nurse would assess as per the existing order from the provider unless it was an emergency. She stated that the nurse would use their best judgment to decide if vital signs should be done more often than the order directs in the case of an emergency. She said the frequency of vital signs, even in the case of a medical transfer, would be determined on a case-by-case basis. 9. On 01/06/23 at 1:30 PM, Investigator #19 interviewed Staff #1907, staff RN, regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with Staff #1906, specifically that the frequency of assessments and vital signs were determined on a case-by-case basis in the event of a change of condition, including any change enquiring transfer to the ED. He stated that the nurse would follow the original order, usually to take vital signs every 4 hours or each shift, and may decide to do them more frequently per the nurse's judgment. 10. On 01/06/23 at 2:00 PM, Investigator #19 interviewed Staff #1904, staff RN, regarding the procedure followed by staff when a change on condition is identified. His answer was in congruence with Staff #1906 and #1907. He stated that the frequency of assessments was determined by the provider's original order except in the case where the RN determines they need additional assessments. He stated that he repeats vital signs at the one hour mark after the identification of a change of condition, but after that frequency is determined on a case-by-case basis. He stated that he would call the doctor if he identified a further				

change of condition during the time they are waiting for transportation to the ED. 11. On 01/06/23 at 2:45 PM, Investigator #19 interviewed Staff #1902, Chief Nursing Officer (CNO), regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with the staff nurse responses, stating that the frequency of assessments and vital signs was determined by the provider's order and, if determined to be needed more frequently by the RN, would be on a case-by-case basis. He said that there is no minimal timeframe for assessment frequency, including in the case of a change				

rec'd 04/12
signed 04/19

South Sound Behavioral Hospital

Progress Report for
State Licensing Compliant Investigation
(Case #2021-13770), 1/05/23-01/16/23

Tag Number	How the Deficiency Will Be Corrected	Date Completed	Results and Monitoring
L355 322-035.1K **POLICIES-STAFF ACTIONS** AC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of policies and procedures, the hospital failed to implement policies and procedures for staff actions upon a serious change of condition as demonstrated by record review of 6 of 6 patients who were transferred to an acute care hospital after identification of a serious change of condition (Patients #1901, 1902, 1903, 1904, 1905, and 1906). Failure to ensure policies and procedures defining staff actions upon a serious change of condition are followed may result in lack of services for patients in need, exacerbation of condition, and death	After this case investigation, a process review was conducted by the medical staff and nursing leadership and the following plan of correction has been/will be made: 1. PC 007: Nursing Assessment and Reassessment has been revised to ensure consistency with practice and what is written on the policy. This was submitted to the committee of the whole (Quality and Med Exec) for approval. a. Section 3.i was revised and states "If a patient is identified to have a physical complaint that warrants closer assessment, the nurse will reassess per provider's order" • This is checking to see if there is a providers order	2/14/2023	Approved revised policy and procedure (see attached revised policy) Daily audit started and monitoring on the following: 1. March audit revealed 79%of the MOT paperwork were

	for reassessment frequency and ensure it was follow by the staff ◦ The re-assessment order will cover the time between the patient is waiting to be transferred to a higher level of care.		completed (necessary field are filled out) with a target of 100% for 3 consecutive months. All non-compliant documentation were identified and corrected. Staff were coached and retrained. Daily auditing and monthly report to Governing board will be continued 2. The orders from the provider if given where followed and documented (March audit revealed 100% with a target of 100%. Monitoring will be continued for April).
	2. All (100%) of active nursing staff and All providers will be trained on the revised policy and procedure for assessment and reassessment by February 28, 2023.	2/28/2023 Regular and PRN Staff that noncompliant with the training were removed from shift. After compliance, staff placed back on schedule.	Audit started in the month of March and will be presented to governing board this April. Target threshold of 100% in 3 consecutive months. All active nursing staff and provider went through the training on revised policy and procedure for assessment and reassessment. Attestation sheets were documented (see attached attendance sheet)
	3. A chart audit of all MOT will be conducted by the nurse managers highlighting on the reassessment order/timeframe on a monthly basis and a threshold of 100% in 3 consecutive months. a) The provider is expected to tell the nurse how often would they like vitals on the patient after receiving the order to send the pt out b) If the provider do not write orders the expectation would be that the nurse takes vitals before calling the provider to assess the situation and depending on the condition that would determine the frequency. Standing orders for	Audit started in the month of March and will be presented to governing board this April. Target threshold of 100% in 3 consecutive months	Monthly audit started and monitoring on the following: 1. Provider order on reassessment (March audit revealed 100% with a target of 100%. Monitoring will be continued for April). 2. Reassessment of the patient done by nursing staff (March audit revealed 100% with a target of 100%. Monitoring will be continued for April).

	assessments and vitals are once every shift.		
Findings included: 1. Document review of the hospital's policy titled, "Nursing Assessment and Reassessment," #PC007, last revised 01/22, showed that, for those patients identified to have a physical complaint such as the flu, bleeding, a wound, or other physical condition warranting closer assessment, the nurse will reassess the patient every hour to monitor for worsening condition until improvement is identified. Patient #1901 2. Patient #1901 was a 34-year-old man admitted on 11/02/21 for alcohol detox and suicidal ideation. An Admission Nursing Assessment, dated 11/02/21, showed that he reported a history of secondary skin infections related to chronic eczema, including a prior severe Methicillin-Resistant Staph Aureus (MRSA) infection that required intravenous Vancomycin, a broad-spectrum antibiotic. He was transferred to an Emergency Department (ED) on 11/08/21 due to a change of condition in which his skin condition was noted to have exacerbated and he had an accompanying fever. He was			

subsequently admitted to the acute care hospital and discharged from the psychiatric hospital. A Psychiatric Note, dated 11/07/21, showed that his skin condition was noted as worsening since admission. A provider consult note, dated 11/07/21, showed that the patient had painful lesions around his wrists that extended to his elbows as well as the back of his neck, ears, and scalp, and that the episode began at the end of the previous week. The order to transfer to acute care was dated 11/07/21 at 3:33 PM. Electronic records of vital signs and assessments showed that vitals were obtained on 11/07/21 at 3:52 PM and showed that the patient had a temperature of 101.7 degrees Fahrenheit. One more set of vitals on 11/07/21 was obtained at 8:40 PM showing a temperature of 101.1. The Memorandum of Transfer (MOT) showed an additional set of vital signs taken at 3:00 PM on 11/07/21. No additional skin assessments were documented between the order for transfer and the transfer. The patient left the hospital on 11/08/21 at 12:15 AM. Patient #1902 3. Patient #1902 was a 56-year-old man admitted on 12/20/22 for Major Depressive Disorder and Alcohol Use Disorder. An Admission Nursing Assessment, dated 12/20/22, showed that the patient had pain, swelling, and redness on his toes that was noted upon admission. The patient had a radiology consultation on 12/22/22 at 6:54 PM; the consult showed the patient had			

osteomyelitis. An order, dated 12/30/22 at 4:43 PM, was given to transfer the patient to the ED for further evaluation. A nurse's note, dated 12/31/22 at 6:00 AM, showed that the patient refused transfer once transportation arrived at the hospital. A second transfer order was obtained, dated 12/31/22 at 6:52 PM. The MOT showed the patient transferred to the hospital on 12/31/22 at 7:00 PM with an additional set of vital signs documented on the MOT for that time. Electronic records showed that vital signs obtained between the initial order for transfer and the transfer were taken as follows: on 12/30/22, vital signs were obtained at 7:44 PM. On 12/31/22, vital signs were obtained at 12:26 PM, 3:30 PM, and 7:11 PM Patient #1903 4. Patient #1903 was a 59-year-old woman admitted on 11/06/21 for alcohol detox. A nurse's note, dated 11/09/21, showed the patient presented with fatigue, weakness, and an unsteady gait and required assistance to ambulate to the restroom. A clinician note, dated 11/10/21 at 2:00 PM, showed that during an attempt to perform a clinical assessment, the patient had to be returned to her room and put back in bed because she could "hardly talk." A nurse's note, dated 11/11/21 at 7:00 PM, showed that the patient continued to appear to decline. A provider's order to transfer her to the ED was obtained on 11/11/21 at 1:00 PM. A provider's note showed that the patient went to the ED with hepatic encephalopathy. The Emergency Transfer Return Note, dated 11/12/21 at 9:00 AM, showed that she had a diagnosis of possible liver failure. The patient had vital signs			

assessed on 11/10/21 at 7:59 AM, 11:58 AM, 4:39 PM, and 8:20 PM. Vital signs obtained on 11/11/21 were as follows: 12:10 AM, 4:01 AM, and 8:39 AM. She was transferred to the ED at 12:45 PM on 11/11/21; an additional set of vital signs were Patient #1904 5. Patient #1904 was a 49-year-old woman admitted on 12/21/22 for suicidal ideation. A nurse's note, dated 12/23/22 at 11:30 PM, after the transfer occurred, showed she presented with chest pain on 12/23/22. No time for the report of chest pain was given. She received one dose of nitroglycerin at 9:45 PM without relief. An order to transfer to the ED was obtained at 10:15 PM, and she left at 10:22 PM on 12/23/22. Review of electronic records showed that only one set of vital signs were obtained on 12/23/22 after the pain was reported; those were taken at 9:07 PM. The MOT reflected an additional set of vital signs obtained at 9:45 PM. Patient #1905 6. Patient #1905 was a 25-year-old man admitted on 11/02/21 for Major Depressive Disorder, Schizophrenia, and Alcohol Use Disorder. Records showed that he had a wound assessed in a consult with a medical provider on 11/04/21 at 1:20 PM. He was transferred to the ED at 3:30 PM on 11/04/21. Electronic records showed no vital signs obtained in the time period between the consult and the transfer. A set of vitals were reflected on the MOT with no time documented. Vital signs obtained on 11/04/21 were at 8:04 AM and 9:26 PM. NNo other assessment is documented. Patient #1906			

7. Patient #1906 was a 33-year-old woman admitted on 12/30/22 for opioid use. An order was obtained on 12/31/22 at 2:34 PM to transfer her "as soon as possible" for likely abscess with phlebitis. MOT, dated 12/31/22, showed that transportation was requested at 4:16 PM and had an estimated time of arrival of 11:00 PM. The MOT and nurse's notes did not reflect the time of departure. The MOT showed vital signs noted as "at time of departure" were obtained at 4:16 PM; the acceptance for transfer from the ED was at 9:00 PM. The Incident Report showed that the patient had an order to go to the ED but also did not reflect time of departure. On 12/31/22, electronic records showed that vital signs were documented for 3:07 AM, 7:45 AM, 2:01 PM, and 7:08 PM. No other assessments were documented from the time the wound was assessed for worsening symptoms until transfer. 8. On 01/06/23 at 1:15 PM, Investigator #19 interviewed Staff #1906, staff Registered Nurse (RN), regarding the procedure followed by staff when a change of condition is identified. When asked about assessments after a change of condition is identified, she stated that the nurse would assess as per the existing order from the provider unless it was an emergency. She stated that the nurse would use their best judgment to decide if vital signs should be done more often than the order directs in the case of an emergency. She said the frequency of vital signs, even in the case of a medical transfer, would be determined on a case-by-case basis.			

9. On 01/06/23 at 1:30 PM, Investigator #19 interviewed Staff #1907, staff RN, regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with Staff #1906, specifically that the frequency of assessments and vital signs were determined on a case-by-case basis in the event of a change of condition, including any change enquiring transfer to the ED. He stated that the nurse would follow the original order, usually to take vital signs every 4 hours or each shift, and may decide to do them more frequently per the nurse's judgment. 10. On 01/06/23 at 2:00 PM, Investigator #19 interviewed Staff #1904, staff RN, regarding the procedure followed by staff when a change on condition is identified. His answer was in congruence with Staff #1906 and #1907. He stated that the frequency of assessments was determined by the provider's original order except in the case where the RN determines they need additional assessments. He stated that he repeats vital signs at the one hour mark after the identification of a change of condition, but after that frequency is determined on a case-by-case basis. He stated that he would call the doctor if he identified a further change of condition during the time they are waiting for transportation to the ED. 11. On 01/06/23 at 2:45 PM, Investigator #19 interviewed Staff #1902, Chief Nursing Officer (CNO), regarding the procedure followed by staff when a change of condition is identified. His answer was in congruence with the staff nurse responses, stating that the frequency of assessments			