STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

September 26th, 2023

Toni Long
Rainier Springs LLC
2805 NE 129th St
Vancouver, WA 98686-3324

Dear Ms. Toni Long,

This document contains information regarding the recent Behavioral Health Agency inspection of Rainier Springs, 2805 NE 129th St, Vancouver, WA. 98686-3324 by the Washington State Department of Health. Your state licensing inspection was conducted between 06/05/23 and 08/09/23 in accordance with WAC 246-341 for Behavioral Health Agency licensing and certification for one or more behavioral health services.

During the inspection, deficient practice was found in the areas listed on the attached Statement of Deficiencies. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 business days after you receive this document.

Each plan of correction statement must include the following:

- The regulation number;
- How the deficiency will be corrected;
- Who is responsible for making the correction;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations.

You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please return the Plans of Correction to me via email.

Please contact me if there are questions regarding the inspection process, deficiencies cited, or completion of the Plans of Correction.

I want to extend another "thank you" to you and to everyone that assisted me during the survey.

Sincerely,

Lisa M Westlund LMHC CMHS CDP
Reviewer

Enclosures: DOH Statement of Deficiencies
Plan of Correction Required Information

Behavioral Health Agency Inspection Report

Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
TEL: 360-236-4732

September 26, 2023

Rainier Springs, 2805 NE 129th St, Vancouver, WA. 98686-3324		Toni Long
Agency Name and Address		Administrator
ONGOING - ROUTINE	06/05 – 08/09, 2023	LMW4303
Inspection Type	Inspection Onsite Dates	Inspector
X2021-10	BHA.FS.60888597	
Inspection Number	License Number	

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

Deficiency Number and Rule Reference	Observation Findings	Plan of Correction
0340 Administrator key responsibilities WAC 246-341-0410(1)(c) (1) The agency administrator is responsible for the day-to-day operation of the agency's provision of certified behavioral health treatment services, including: (c) Meeting all applicable rules, policies, and ethical standards.	Based on clinical record review and interview, the agency failed to be responsible for meeting all applicable rules pertaining to ensuring clinical records authenticated and were completed fully for 5 of 13 records reviewed (Client #1, #2, #3, #6, #12 and #13). Failure to ensure the clinical documentation meets all the WAC required elements may lead to misrepresentation of staff, inability to identify staff practicing within their scope, inadequate service delivery, poor Client outcomes, and potential public health risks.	Leadership from nursing, clinical services, and assessment/intake will re-educate and retrain employees on the WAC 246-322-010(4)(a)(4) and WAC 246-322-200(4)(a-c) authentication of a record. This will include: a signature with the first and last name of the person completing the documentation, professional title, and discipline; prompt completion of documentation and ensuring all necessary signature are obtained; authentication of orders for care, treatment, and any standing medical

	1. Review of facility licensing and certifications showed the agency is licensed as a Private Psychiatric and Alcoholism Hospital (HPSY) in addition to the BHA inpatient and outpatient treatment certification. As a HPSY, clinical records must follow applicable chapter 246-322 WAC. This includes the following applicable rules: WAC 246-322-010(4)(a)(4) "Authenticate" means to authorize or validate an entry in a record by: (a) A signature including first initial, last name, and professional title/discipline. WAC 246-322-200(3)(e)(iii) Clinical records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders. And WAC 246-322-200(4)(a-c) The licensee shall ensure each entry includes: (a) Date; (b) Time of day; (c) Authentication by the individual making the entry. 2. Review of agency clinical records for Clients #1, #2, #3, #6, #12, and #13 showed multiple deficiencies related to record entry as evidenced by the following: Item #1 – HIV/AIDS Risk Assessment Form a. Review of the clinical record for Client #1 showed the HIV/AIDS Risk Assessment was completed on 05/13/23 at 11:00 AM. The form is not authenticated as the signature is illegible and staff title/discipline is not listed.	orders used in the care and treatment of the patient. The staff will be retrained on all documentation within the intake packet, progress notes, etc. no later than 11/1/23. Intake/Assessment employees will ensure that all documentation is completed in its entirety (including legible signatures, date/time, professional title, and credentials) prior to the patient being escorted to the unit. The staff will review all intake paperwork to ensure that they have signed each form with a legible signature, printed name, date of the intake, time of the intake, and their credentials. The staff's immediate supervisor will provide coaching to all staff who do not complete this task. Leadership will discuss any discrepancies with their staff in their one-on-one meetings. The Director of Assessment, Director of Nursing, Director of Clinical Operations and/or their designee will conduct 20 open patient record audits per month for completion and legible signatures, employees' credentials, and the date / time the signatures were written. The audit will include

	b. Review of clinical record for Client #6 showed an included HIV/AIDS Risk Assessment which was not completed. c. Review of clinical record for Client #13 showed a HIV/AIDS Risk Assessment with no date of completion. Item #2 – Intake Assessment documentation a. Review of the clinical record for Client #1 showed the Intake Assessment was completed on 05/13/23. The documentation had an illegible staff signature with no identified credentials or time of service. b. Review of the clinical record for Client #12 showed the Intake Assessment was completed 05/14/23 with multiple incomplete sections and an illegible staff signature. Item #4 – Home Medication Belongings Form Review of the clinical record for Client #2 showed no staff signature, no date, and no time of day on the Home Medication Belongings Form. Item #5 – 12 Panel Urine Drug Screen/Human chorionic gonadotrophin (UDS/HcG) Form Review of the clinical record for Clients #2, #3, and #13 showed no staff signature or credentials, no date, no time of day on the 12 Panel UDS/HCG form. Item #6 – Nursing Clinical Note	the review of the HIV/AIDS Risk Assessment, Intake Assessment, home medication belonging, 12 Panel Urine Drug Screen/Human chorionic gonadotrophin (UDS/HcG), and the nursing clinical note forms are completed in its entirety. The audit will ensure that the author of the note will X out any additional blank lines on the form, have legible signatures, date/time, and credentials. Night nursing staff will conduct nightly audits of open patient records to ensure that all forms have an employee printed name, legible signature, date of intake, time of intake, and the employee credentials. Target compliance is 90% or more of the charts audited have the required elements. Audits will continue monthly until 90% compliance is achieved for 3 consecutive months. Feedback from the audits will be discussed weekly in the administrative huddles, monthly in quality committee, and quarterly in board meetings.

	a. Review of the clinical record for Client #2 showed no staff signature or credential on the note. The documentation appeared to have clinical documentation for two different staff members without indication of who documented what information on the form. b. Review of the clinical record for Client #12 showed the note completed on 05/14/23 had no staff signature or credential. 3. During an interview on 06/06/23 at 3:50 PM, the Reviewer asked Staff A, Director Quality, Compliance, and Risk, to explain the Quality Management process for clinical records. Staff A stated after Client discharge the Health Information Managers pull charts and scan documents into the record system. Staff A stated a records review occurs once a month and is conducted by department directors. the Reviewer asked if any staff review the clinical records for completion prior to a client discharge. Staff A stated no one reviews the chart prior to discharge.	
0355 Administrator key responsibilities WAC 246-341-0410(4)(a) (4) The administrator or their designee must ensure: (a) Administrative, personnel, and clinical policies and procedures are adhered to and compliant with the rules in this chapter and other applicable state and federal statutes and regulations.	Based on policy and procedure review and interview, the agency failed to ensure policies and procedures (P&P) met current WAC rules. Failure to maintain policies and procedures for current, WAC rules and other applicable state and federal statutes and regulations may result in violations causing harm to Clients, and staff. 1. During an interview on 06/05/23, the Reviewer asked Staff A, Director of Quality, Compliance, and Risk, for	Leadership will ensure that all administrative, personnel, and clinical policies and procedures are adhered to and compliant with the WAC 246-341-0410(4)(a)(4) statues and regulations. The Director of Quality (DOQ) and/or their designee will conduct at least 10 monthly reviews of policies to ensure they are updated according to the

	agency BHA Policy and Procedures. Staff A stated that with the recent agency mergers procedures were in the process of revision and updates. Staff A provided a notebook of existing P&Ps. 2. Review of the policy and procedure notebook showed policies referencing BHA WAC 246-341 were last reviewed 06/2021 and next review was set for 06/2024. The agency administrator or their designee failed to ensure the P&Ps were updated for WAC 246-341 revised and certified on 12/29/22 and effective 05/01/23.	Washington State revisions and standards. All policies pertaining to Rainier Springs will be reviewed annually to ensure that all Washington standards are addressed and met. The DOQ and/or their designee will review policies that are up for renewal and if there are any changes needed ensuring that the policy has been updated and/or revised with any additional standards. All necessary policies have been revised as of 10/15 according to the WAC standards. Target compliance is 90% or more of the policies audited have the required elements. Feedback and revisions of policies will be reviewed within the monthly Policy/Forms meeting, monthly Quality Committee, and quarterly in board.
0470 Agency policies and procedures WAC 246-341-0420(9) Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following, as	Based on document review and interview, the agency failed to implement procedures for reporting of impaired practitioners in accordance with chapter 18.130 RCW for 2 of 12 staff reviewed (Staff #136 and 176). Failure to report impaired practitioners in accordance with chapter 18.130 RCW may result in health care facility investigation, cause client harm due to	During discussions with the DOH auditor, it was felt on the part of the CEO and HR that lack of professionalism on part of staff, which did not directly affect ongoing patient care, was a reportable issue for the facility. In the two incidents reviewed it was determined that appropriate steps and actions were taken on the part of the department leadership to ensure that groups continued to occur as scheduled, and that direct patient care

applicable: (9) Reporting of impaired practitioners in accordance with chapters 18.130 RCW and 246-16 WAC.	unreasonable risks, and poor client treatment outcomes. **Rule Reference:** RCW 18.130.080(1)(b)(i) Every license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder shall report to the disciplining authority when the employed license holder's services have been terminated or restricted based upon a final determination that the license holder has either committed an act or acts that may constitute unprofessional conduct or that the license holder may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition. 18.130.180 Unprofessional Conduct (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, (4) Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed. (14) Failure to adequately supervise auxiliary staff to the extent that the consumer's health or safety is at risk; ... 1. During a review of the personnel records for Staff #176, Inpatient Therapist, on 06/06/23 showed that they had been terminated on 09/12/22. The personnel file for Staff #176 did not contain any documentation regarding the termination.	was at no time affected. Further, issues that did rise to a level of reporting to the Department of Health were dismissed stating that there was no other need to move forward as the DOH did not feel they met criteria for reporting. Therefore, we find it difficult to reconcile the need to report facility level personnel issues that were appropriately managed in the facility with those which were reported and subsequently dismissed. In cases of immediate staff departures outside of normal voluntary resignations, the HR department and appropriate department Leader will confer to determine the need for reporting to DOH as required. Rainier Springs will continue with existing practices to ensure that any supporting documentation regarding the departure of staff will be appropriately documented and filed in the employee record prior to storage or record retirement. We will continue to evaluate each individual situation as they arise. Department Leadership promptly reports the incidents of impromptu departures to HR and Quality to determine if there could be any potential restrictions which may need to be applied.

	2. Review of Staff #176 further determined this staff member did not have any active credentials for clinical services from date of hire through July 2022. As a Therapist in a BHA, Staff #176 is required to have a credential for scope of practice. In July 2022, DOH issued a Mental Health Counselor License to Staff #176 requiring compliance with 18.130 RCW. 3. During an interview on 06/06/23 at 1:45 PM, the Reviewer asked Staff E, Human Resource Business Partner, about the circumstances of Staff #176 termination. Staff E stated the file had no documents and needed to explore the situation further. At 3:40 PM, Staff E stated that Staff #176 had multiple call-outs, would not provide scheduled treatment groups when on site and in building resulting in cancelled treatment or other staff covering, and supervisors noted the staff member failed to engage with clients. Staff E stated this staff member abruptly left the facility on 07/22/22 and did not return. The Reviewer asked Staff E if the BHA had reported the staff member to DOH Professions due to the level of repeated unprofessionalism. Staff E stated the staff member was not reported. 4. During an interview on 09/08/23 at 9:35 AM, the Reviewer asked Staff E, Human Resources Business Partner, about the credentialing status for Staff # 138, Personal Care Assistant. Staff #138 provided direct care to clients and held a CNA credential. Staff E stated Staff #138 abruptly quit during the graveyard shift. Per Staff E, Staff #138 "walked off in the middle of the night". Staff E stated being unsure if actions would be unprofessional conduct and that Staff #138 was not interviewed about the abrupt quitting. Staff E stated no	

	when the Reviewer asked Staff E if Staff #138 had made arrangements for other staff to be called on duty to ensure no unreasonable risk to clients. Staff E stated the facility transferred around staff members on the units allowing for minimal staff coverage and no client situations occurred. The Reviewer identified the BHA had addressed the staffing need but not the conduct of Staff #138 as creating a potentially facility safety concern. The Reviewer reiterated that the reporting of acts that may constitute unprofessional conduct is a regulatory requirement to ensure client, facility, and community safety.	
0485 Agency policies and procedures WAC 246-341-0420(12)(a-d) Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following, as applicable: (12) Reporting critical incidents. A description of how the agency directs staff to report to the department within 48 hours any critical incident that occurs involving an individual, and actions taken as a result of the incident. A critical incident is a serious or undesirable outcome that occurs in the agency including: (a) Allegations of abuse, neglect, or exploitation. (b) Death, including death by suicide. (c) Injuries resulting in admission to a	Based on policy and procedure review and clinical record review, the agency failed to implement policy and procedure for reporting critical incidents to the department for incidents identified in BHA WAC. Failure to develop policy and procedure that addresses all of the applicable licensing and certification requirements can result in poor patient outcomes, places patient safety at risk, and jeopardizes the agency licensing and credentialing. Findings included: 1. Review of agency policy and procedure titled, "Incident Report Protocol and Patient Safety Events", policy number 12910245, effective 01/2023, does not refer to any Washington State Behavioral Health Regulations. The policy does not refer to reporting of incidents to the Department of Health.	The Director of Quality and/or their designee will ensure that all aspects of WAC 246-0420 are added to the Incident Reporting Protocol and Patient Safety Events policy. The policy will be revised to incorporate the language surrounding state standards regarding reportable incidents: allegations of abuse, neglect, or exploitation, death, including death by suicide, injuries resulting in admission to a hospital as an inpatient, outbreak of communicable disease, and the timeframes to report such incident to the state. This was completed as of 10/15/23. All staff will receive re-education and training on the new policy and the components of the policy by 11/1/23.

hospital as an inpatient. (d) Outbreak of communicable disease within the agency.	2. Review of clinical record for Client #2 showed on 02/04/23 the client was discovered on the floor with a laceration to their forehead. The progress note documented at 5:00 PM "per Legacy Nurse, pt [patient] will be admitted. Pt [patient] will be inpt [inpatient] in Legacy Salmon Creek." 3. Review of agency critical incident report log shows Staff A did review the circumstances of the incident and it was determined to be a Patient Safety Incident. No report was made to DOH per WA BHA WAC requirements.	Incident reports are discussed daily in Flash, weekly in the leadership meeting, monthly in quality committee, and quarterly in board. Any incident that meets the WAC standard of being reportable will be reported to DOH within 48hrs of the event. All staff have received the mandatory training on abuse reporting and what incidents are required to be reported to the state within 48hrs. DOQ will review all incidents with the CEO weekly. Target compliance is 90% or more compliance of the state reportable incidents being reported.
0570 Agency policies and procedures WAC 246-341-0420(17)(d) Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following, as applicable: (17) Personnel policies and procedures must address the following: (d) Staff training. A description of how the agency provides training initial orientation and annual	Based on policy and procedure review, personnel record review and interview, the agency failed to implement procedures for staff training for 6 of 6 staff reviewed (Staff #15, #24, #77, #113, #142, and #157). Failure to provide and document staff training may result in staff violating State regulatory standards and places Clients at risk due to potential staff barriers when providing treatment. Lack of appropriate training may result in poor Client outcomes, lack of Client engagement, as well as care that may not meet licensing requirements. Findings included:	HRBP and Leadership will ensure that all administrative, personnel, and clinical policies and procedures are adhered to and compliant with the WAC 246-341-0420(17)(d) statues and regulations. Prior to any new employees engaging in face-to-face care of patients they receive lifesaving training prior to the start of their first shift. All newly hired employees are expected to complete the CPR/First Aid within the first week of employment.

training thereafter in accordance with WAC 246-341-0510.	1. Review of agency Policy and Procedure titled, "Staff Orientation Education, Development and Competency Plan for Clinical Facilities", policy number 9819648, effective 06/2021, showed under no circumstances will direct care staff be allowed to work independently on a patient unit without Cardiopulmonary resuscitation (CPR) certification. This policy is not being followed. 2. Review of personnel records showed 6 staff members, Staff #15, #24, #77, #113, #142, and #157, required CPR training. 3. During an interview on 06/05/23 at approximately 1:00 PM with Staff E, Human Resources Business Partner, the Reviewer asked Staff E how the agency monitored required training. Staff E stated that verification review occurred every Tuesday for training requirements. Staff E acknowledged that the current listing showed 6 staff needing CPR training. Staff E stated that these staff were likely not working independently. 4. Review of staff job titles and agency schedule showed Staff #15, #24, #77, #113, #142, and #157 had duties which would have these staff members working independently providing patient care.	A tickler system has been developed to ensure that employees and their supervisors are reminded of any upcoming license renewal needs. This tickler system is housed in the educational/training platform which sends out daily reminders the month prior to the license expiration date. HRBP conducts weekly audits of at least 10 personnel files to ensure that all required trainings have been completed, ensuring their license is still valid, and communicating out to employees of their upcoming expirations on life saving trainings and license renewal. All employees are required to have and maintain an active current CPR card based on their role within the hospital. If their card expires employees will be removed from the schedule until the issue has been rectified. Target compliance is 90% or more of the files audited have the required elements. Audits will continue monthly until 90% compliance is achieved for 3 consecutive months. Feedback from audits is discussed daily in Flash, weekly in leadership,

		monthly in quality committee, and quarterly in board. Additionally, the CPR trainers have taken steps to add additional classes to accommodate the team members who maintain full time employment at other companies to allow a more flexible schedule to train on CPR/First Aid. This has been implemented as of 10/1/23.
0705 Personnel-Agency record requirements WAC 246-341-0510(1(f) A behavioral health agency must maintain a personnel record for each person employed by the agency. (1) The personnel record must contain all of the following: (f) A copy of the staff member's valid current credential issued by the department if they provide clinical services. 0720 Personnel-Agency staff requirements WAC 246-341-0515(1) Each behavioral health agency must ensure that all of the following staff requirements are met: (1) All staff providing clinical services are appropriately credentialed for the services they provide, which may include a co-occurring disorder specialist enhancement.	Based on personnel record review and interview, the agency failed to ensure each person employed by the agency had a valid current credential issued by the department if they provided clinical services for 17 of 17 staff reviewed (Staff I, #1, #5, #8, #35, #36, #40, #60, #68, #93, #106, #107, #127, #141, #146, #157, and #159). Failure to ensure staff are appropriately credentialed and supervised for the clinical services they provide potentially endangers Clients and opens an agency to liability concerns if personnel are unqualified for providing clinical services. Findings included: 1. Review of the personnel records for staff showed that the personnel records did not have a staff member's valid current credential as evidenced by the following: a. 7 staff had expired credentials and 10 staff did not have current credentials to provide clinical services.	HRBP and Leadership will ensure that all administrative, personnel, and clinical policies and procedures are adhered to and compliant with the WAC 246-341-0510(1)(f) and WAC 246-341-0515(1) statues and regulations. After review with the DOH Surveyors it was determined that patient facing staff providing face to face care to patients will have an approved license or certification on file. As a result, all staff that do not carry a specialized license will be required to obtain the State of Washington Department of Health "Agency Affiliated Counselor" license. This was addressed immediately after the surveyor's review. All newly hired staff members are expected to apply for the license within

	2. During an interview on 06/05/23 at approximately 1:00 PM, the Reviewer asked Staff E how the agency verified staff had active credentials. Staff E, Human Resources Business Partner, stated that verification review occurred every Tuesday for expiration of credentials. Staff E acknowledged that the current credential listing showed 7 staff with expired credentials. 3. During an interview on 06/05/23 at approximately 1:00 PM, the Reviewer asked Staff A, Director of Quality, Compliance, and Risk, for agency BHA Policy and Procedures. Staff A stated that with the recent agency mergers procedures are in the process of revision and updated. 4. During an interview on 06/05/23 at 1:15 PM with Staff A, Director of Quality, Compliance, and Risk, the Reviewer asked which BHA staff are required to have credentials. Staff A stated inpatient staff are not licensed as the previous HR person said it wasn't necessary as they were covered under the BHA license. 5. During an interview on 06/05/23 at 1:30 PM the Reviewer asked Staff E why staff on the inpatient unit would not have a DOH credential. Staff E, Human Resources Business Partner, stated the agency does not require inpatient to be credentialed as they are covered under the facility license. Staff E indicated having been told this information by Staff I, Director of Clinical Services.	the first 30 days of employment. HR will conduct routine audits on all licensing held within the facility to ensure compliance. Those nearing expiration within 30-60-90 days will be directed to appropriate Department of Health site to renew prior to expiration. All staff that fail to obtain and maintain the licensure will be removed from the schedule until they can become current. Failure to maintain current licensure may result in Corrective Actions up to and leading to termination of employment. Target compliance is 90% or more of the charts audited have the required elements. Audits will continue monthly until 90% compliance is achieved for 3 consecutive months. Feedback from audits is discussed daily in Flash, weekly in leadership, monthly in quality committee, and quarterly in board. A tickler system has been developed to ensure that employees and their supervisors are reminded of any upcoming license renewal needs. This tickler system is housed in the educational/training platform which sends out daily reminders the month prior to the license expiration date.

	6. During an interview on 06/06/23 at 11:05 AM the Reviewer asked Staff I, Director of Clinical Services, to explain credentialing for inpatient staff. Staff I stated the previous management said individual credentialing was not needed for the staff providing clinical treatment on the inpatient unit as they are covered by the BHA license. Staff I stated being unfamiliar with the Agency Affiliate credentialing for Washington. 7. During an interview on 06/06/23 at 11:45 AM, the Reviewer asked Staff H, Director of Outpatient Services, about knowledge pertaining to agency and clinical staff credentialing. Staff H stated having discussed credentialing with the previous CEO and being told no credentials were needed to work on the inpatient unit. Staff H stated knowing this was wrong and stopped providing inpatient supervision. Staff I was hired for those duties. 8. During an interview on 06/07/23 at 11:22 AM, the Reviewer notified Staff B, Chief Executive Officer, of scope of practice credentialing situation. Staff B stated awareness that previous management was not compliant with ensuring credentialing. Staff B stated the agency will immediately have staff apply for credentialing.	
0780 Individual rights WAC 246-341-0600(1) (1) Each behavioral health agency must protect and promote individual participant rights applicable to the services the agency is certified to provide in compliance with this chapter, and chapters 70.41, 71.05, 71.12, 71.24, and 71.34 RCW, as applicable.	Based on observation and documentation review, the agency failed to promote individual rights applicable to services the agency is certified to provide in compliance with this chapter for 11 of 11 client clinical records reviewed (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11).	Leadership will ensure that all administrative, personnel, and clinical policies and procedures are adhered to and compliant with the WAC 246-341-0600(1) statues and regulations pertaining to patient rights.

	Failure of the agency to protect and promote individual rights consistent with the most current WAC 246-341 may result in agency staff violating individual rights that may result in individual harm to the Client, and jeopardizes the BHA license, and may lead to investigation and fines, and potentially places staff at risk for liability claims. Findings included: 1. Observation of the posted, "Notice of Right", on 06/05/23 at 10:00 AM showed that the posted "Notice of Rights" only pertained to chapter 71.05 and did not include any references to Washington Department of Health Behavioral Health Agency participant rights. 2. Review of the admission packet documentation showed no record content for notice of rights for chapter 246-341 WAC. 3. Review of the document titled, "Application of Voluntary Admission WASHINGTON", cites "Admission is in Accordance with Sections 5122.02 and 5122.03 O.R.C." which was determined to be Ohio State regulations. There is no indication of Washington Regulations on the form. 4. Review of the document titled, "Patient Bill of Rights Washington", cites only rights under chapter 71.05 RCW. There is no statement of individual participant rights that specifically addressed the rights incorporating chapter 246-341-0600 Individual Rights.	The policy will be revised to include Washington State's specific language regarding patient rights. This will be completed no later than 10/15/23. Leadership has worked on updating the posting in the common areas to include the Washington State language. The new posting should be up by 11/1/23. Director of Assessment has updated the forms within the intake packet to ensure the current WAC language is placed in the patient rights notice. This has been completed as of 10/15/23. The Application of Voluntary Admission Washington has been revised to include the current state and standard. This has been completed as of 9/27/23 and has been implemented as of 10/1/23. Leadership and/or their designee will conduct 10 chart audits to ensure that all patient files contain patient bill of rights, the application of voluntary admission forms are signed with the first and last names, date/time signature obtained, and credentials.

	5. Review of clinical records for Clients #1 - #11, showed no evidence that Client's received notice of individual rights for BHA license and certified services for chapter 246-341 WAC.	Target compliance is 1000% or more of the charts audited have the required elements. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Feedback from audits is discussed daily in Flash, weekly in leadership, monthly in quality committee, and quarterly in board.
0855 Individual rights WAC 246-341-0600(3)(d) (3) Each agency must ensure the applicable individual participant rights described in subsections (1) and (2) of this section are: (d) Posted in public areas.	Based on observation and interview, the agency failed to ensure promotion of individual rights applicable to services the agency is certified to provide in compliance with this chapter and post these rights in public areas. Failure of the agency to protect and promote individual rights consistent with the most current WAC 246-341 may result in agency staff violating individual rights that may result in individual harm to the Client, and jeopardizes the BHA license, and may lead to investigation and fines, and potentially places staff at risk for liability claims. Findings included: 1. Observation of the posted, "Notice of Rights", on 06/05/23 at 10:00 AM showed that the posted "Notice of Rights" only pertained to chapter 71.05 and did not include any references to Washington Department of Health Behavioral Health Agency participant rights.	Leadership will ensure that all administrative, personnel, and clinical policies and procedures are adhered to and compliant with the WAC 246-341-0600(3)(d)(3) statues and regulations pertaining to patient rights. Leadership has worked on the posting in the communal areas to include the Washington State language. The new posting should be up by 11/1/23. DOQ will ensure that the posting remains up to date with changes made to WAC 246-341-0600(3)(d) (3). DOQ will audit the patient rights standards annually to ensure that any new language placed in this WAC is also in agency policies and on any public postings.

	2. During an interview on 06/05/23 at 11:45 AM, the Reviewer asked Staff C, Senior Director of Business Development, about Notice of Rights for the Behavioral Health Services. Staff C stated that entry points have posted notices of rights and clients receive copies of notifications during admission. Staff C was unfamiliar with Individual Rights specific to the BHA license.	
2975 Withdrawal management WAC 246-341-1100(3)(a) (3) Ensure that each staff member providing withdrawal management services to an individual, with the exception of substance use disorder professionals, substance use disorder professional trainees, physicians, physician assistants, advanced registered nurse practitioners, or person with a co-occurring disorder specialist enhancement, completes a minimum of 40 hours of documented training before being assigned individual care duties. This personnel training must include the following topics: (a) Substance use disorders. (b) Infectious diseases, to include hepatitis and tuberculosis (TB). (c) Withdrawal screening, admission, and signs of trauma.	Based on policy and procedure review and interview, the agency failed to ensure that each staff member providing withdrawal management services completed a minimum of 40 hours of document training before being assigned individual care duties for inpatient clinical staff. Failure to provide and document staff training may result in staff violating State regulatory standards and places Clients at risk due to potential staff barriers when providing treatment. Lack of appropriate training may result in poor Client outcomes, lack of Client engagement, as well as care that may not meet licensing requirements. Findings included: 1. During interview on 06/05/23 at 11:25 AM the Reviewer asked Staff A, Director Quality, Compliance, and Risk, to describe the treatment units and facility services to determine specific staffing patterns and training requirements for BHA Certified Services. Staff A stated the facility provides co-occurring treatment and individuals receiving withdrawal management are placed into any of the facility units based upon assessment. Staff A stated those with primary Substance	Leadership will train employees on Withdrawal management in accordance with the WAC 246-341-1100(3)(a) (3). The Director of Nursing (DON) and/or their designee will provide training to all employees on Withdrawal management. DON has worked with the Corporate VP of nursing in developing comprehensive training. All patient facing employees that have not received this training as part of their degree and/or licensure requirement will receive this training. The training will include the numerous substances use disorders, infectious diseases (including hepatitis and TB), withdrawal screening, admission, and signs of trauma. All employees will be trained by 11/1/23. Any employee who has not received this training by 11/1/23 will be removed from the schedule until they complete the training in its' entirety.

	Use Disorder (SUD) diagnosis and minimal mental health are assigned to the Sunrise unit. Staff A stated the facility can provide Withdrawal Management for up to 24 individuals yet the facility limits capacity to 18. Staff A stated facility acuity determines capacity and placement. Staff A stated yes when Reviewer asked if individuals receiving Withdrawal Management would be placed on any unit and provided treatment services by all staff on those units. Staff A stated Staff E would know staff training requirements. 2. Review of agency Policy and Procedure titled, "Staff Orientation Education, Development and Competency Plan for Clinical Facilities", policy number 9819648, effective 06/2021, identified each staff member providing withdrawal management services to an individual except for licensed staff members must complete a minimum of forty hours of documented training. This policy is incorrect. 3. During an interview on 06/05/23 at 3:30 PM the Reviewer asked Staff E, Human Resource Business Partner, for verification that non-prescriber or SUD staff on the inpatient unit were being trained on withdrawal management. Staff E stated they would need to review the training records. Staff E was asked to identify the specific on-boarding training components to determine if they match required training. 4. During an interview on 06/06/23 at 11:30 AM the Reviewer asked Staff J, Provider Onboarding Administrative Assistant, to describe the withdrawal management training required for staff. Staff J stated job duty is only for monitoring onboarding for	HRBP will provide a list of current employees who have not received this training to the respected leader to ensure their employee attends. HRBP will ensure that this training is assigned to new hires upon their first week of employment. Leadership will review the list of employees weekly in the leadership meeting. The Staff Orientation Education, Development and Competency Plan policy will be revised to include Washington State's specific language regarding withdrawal management. This was completed as of 10/15/23. HRBP will audit 10 employee files per month to ensure compliance with this regulation. HRBP will continue to communicate to employees the due dates for training. Target compliance is 100% or more of the personnel files audited have the required elements. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Feedback from audits is discussed daily in Flash, weekly in leadership,

	prescribers, nursing staff, and patient care aides (PCA). Staff J stated facility requires those staff to onboard for one week on the SUD unit and have one on one training during this week on Withdrawal Management. 5. During an interview on 06/06/23 at 11:45 AM the Reviewer asked Staff E, Human Resources Business Partner, for update on determination of verification of Withdrawal Management training for inpatient mental health staff working with co-occurring patients. Staff E stated at 11:45 AM specific orientation for withdrawal management and tracking of completion was not identified by Human Resources.	monthly in quality committee, and quarterly in board.

Introduction
We require that you submit a plan of correction for each deficiency listed on the inspection report form. Your plan of correction must be submitted to the DOH within ten business days of receipt of the list of deficiencies.

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

An acceptable plan of correction must contain the following elements:

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

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

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

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

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

Checklist:

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

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

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

Approval of POC

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

Questions?

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

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

10/31/2023

Toni Long
Rainier Springs LLC
2805 NE 129th St.
Vancouver, WA 98686-3324

Re: Exam Number: X2021-10
License Number: BHA.FS.60888597
Approved Plan of Correction
Date(s) of Inspection: 06/05/23 – 08/09/23

Dear Administrator:

This letter is to inform you that after careful review of the Plan of Correction (POC) you submitted for the exam recently conducted at your facility, the Department has determined that the POC is approved.

Based on the scope and severity of the deficiencies listed in your statement of deficiency report, the Department **will not** conduct an announced follow-up compliance visit to verify that all deficiencies have been corrected.

Reviewer: LMW4303
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874