STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE COMPLAINT SURVEY 2nd FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint follow-up survey. Onsite dates: 07/16/18 to 07/17/18 Intake number: 79682 The survey was conducted by: Surveyor #3 Surveyor #4 Surveyor #5 Surveyor #11 This 2nd follow-up survey resulted from a follow-up survey in which the facility was found NOT IN COMPLIANCE with Medicare Conditions for Participation set forth in 42 CFR Part 482. During this on-site visit, Department of Health staff determined that the facility remained NOT IN COMPLIANCE with the following Medicare Conditions for Participation set forth in 42 CFR Part 482: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient's Rights	A 000	2nd Revisit Rec'd 8/9/18 Approved - 8/21/18	
{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is	{A 043}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 043}	Continued From page 1 legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on document review, medical record review and interview, the hospital's governing body failed to provide effective oversight of the hospital. Failure to provide effective oversight to prevent substandard practices for patient safety, and patient rights, resulted in an unsafe environment for patients. Findings included: Observations, interviews, record reviews, and review of hospital policies and procedures, showed the following: 1. The hospital failed to ensure patients received timely results for laboratory tests and dietary consultations during their hospitalization. Cross Reference: A0068 2. The hospital failed to provide for patient safety and protection from self-harm. Cross Reference: A0115 Due to the severity of deficiency under 42 CFR 482.12, the Condition of Participation for Governing Body was NOT MET.	{A 043}	**A 043 Plan of Correction for Each specific deficiency Cited:** The hospital failed to provide effective oversight to prevent substandard practices for patient safety, and patient rights, resulted in an unsafe environment for patients. **Procedure/process for implementing the plan of correction:** • SPBH Governing Board provides over sight to this Plan of Correction for the findings of the follow-up survey by: o Reviewing the plan of Correction to assure the corrective action for deficiencies are clinically indicated and responsive to the Conditions of Participation cited; are sufficient to prevent recurrence of the deficiencies; to make certain patients' rights are protected and patients are receiving appropriate care with positive outcomes. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Governing Board will receive communication from the CEO of SPBH on a monthly basis as to monitoring and evaluation of actions taken and review the statistical results of the ongoing QAPI reporting and make recommendations as needed. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • A member representative of the	8/9/2018

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

- The Governing Board also made the change of the CEO reporting directly to the US HealthVest COO ensuring a more tightly organized Governing Board.

Individual Responsible:

CEO

Date Completed:
8/9/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 043}	Continued From page 2	{A 043}	**A 068 Plan of Correction for Each specific deficiency Cited:** The hospital failed to verify that written orders were carried out.	8/9/2018
{A 068}	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: . Based on Interview, record review, and review of hospital policies and procedures the Governing Body failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs in a safe environment for 2 of 5 patients reviewed (Patient #502 and #503). Failure to provide patients with medical services that meet the patient's healthcare needs in a safe environment risks deterioration of the patient's condition and poor healthcare outcomes. Findings included:	{A 068}	**Procedure/process for implementing the plan of correction:** • A Kardex system has been implemented on units to track lab orders and results, dietary consults, and many other patient orders and activities. The Kardex system now is the source document for nursing shift report. Nurses use the Kardex to track labs, consults, x-rays, off site doctor visits, precautions, allergies, and more. • If STAT labs are ordered, the patient is sent out to the ER for those lab tests. • Nurses were trained on the ability to go online, login and check for any lab results pending on 8-6-2018 to 8-9-2018 or before their first shift worked. • A downtime policy developed by both the contracting lab company and SPBH was created to eliminate any downtime when a situation occurs when the lab servers are not available. • Nurses were re-educated by the CNO/ Designee on 8-6-18 to 8-9-18 or before working their first shift following the changes. • Dietary Consults: The policy and procedure "Nutritional Screen and Assessment 5/17 has been revised to include "A dietician Consult Form" #4 page 1 of 1 will be completed for each patient admitted. The form will indicate if the patient does or does not require a dietician consult. • Nurses were educated on 8-6-18 to 8-9-18 or before working their first shift following the changes, by the CNO/	

Designee regarding the changes in process and the new policy.

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

- Nursing now audits at least 10 charts per day 5 days a week to ensure staff compliance with corrective action plan.

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

- The CNO/designee will issue monthly reports of compliance to the Performance Improvement Committee then communicated to the Governing board monthly.
- The CNO presents the data at the PI committee resulting numbers and ensures a new corrective action plan is complete if the compliance drops below 80% for 2 continuous months. The audit is ongoing until 90% monthly compliance rating is achieved for 3 continuous months.

Individual Responsible:

CNO/Designee

Date Completed:
8/9/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 068}	Continued From page 3 1. Document review of the hospital's policy and procedure titled, "Laboratory Services," no policy number, effective date 05/17, showed that STAT (immediately, without delay) laboratory results will be available from the lab via phone or fax within 4 hours of notification of the need for a STAT lab draw by the hospital. Document review of the hospital's policy and procedure titled, "Nutritional Assessment Process," no policy number, effective date 05/17, showed that nutritional consults will be completed within 3 days of receiving an order for a nutrition consult. 2. On 07/16/18 at 9:15 AM, Surveyor #5 and the Director of Clinical Services (Staff #503) reviewed the medical record of Patient #502, who was admitted on 07/13/18 for the treatment of depression and suicidal ideation. The patient had been admitted from an emergency room where she was treated for a suicide attempt and hyponatremia (low sodium in the blood) with a blood sodium level of 125 mmol/L (normal range 135-145 mmol/L). The medical record review showed: a. The Intake Call sheet completed prior to the patient's admission on 07/12/18 at 4:00 PM stated, "Sodium needs to be in range, and then re assess. Sodium is 128. ..will call tomorrow after labs are re-drawn". The nurse-to-nurse report sheet completed on 07/13/18 at 2:30 PM, showed that the patient's sodium was less than 130 mmol/L. b. On 07/13/18 at 4:08 PM, the hospital's Admission Orders showed that clinical staff	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 068}	Continued From page 4 placed the patient on a 1,000 cc fluid restriction and ordered a Comprehensive Metabolic Panel (a lab test that includes a test of blood sodium levels). Surveyor #5 found no evidence the medical or nursing staff received or reviewed the lab results. c. On 07/14/18 at 4:00 PM, a provider ordered a STAT (immediate, without delay) Basic Metabolic Panel (a lab test that includes a test of blood sodium levels). Surveyor #5 found no evidence the medical or nursing staff received or reviewed the STAT lab results. 3. At the time of the medical record review, the charge nurse (Staff #502) stated that she was unaware that the hospital had not received the results. She stated that she had just completed orientation and she was unaware of the process for tracking ordered tests. The charge nurse showed Surveyor #5 a binder used for communication between charge nurses. Neither Surveyor #5 or Staff #502 found evidence the staff were aware of the STAT lab test, or communication that the STAT lab results had not been received by the hospital. At this same time, the Director of Clinical Services (Staff #503) and the Infection Preventionist/Educator (Staff #504) confirmed the finding and began their investigation of the missing test results. 4. On 07/16/18 at 3:45 PM, the Chief Executive Officer (Staff #505) presented Surveyor #5 with a "Computer Downtime Lab Results" form with the Basic Metabolic Panel test results from 07/14/18 hand written onto the form. Staff #505 stated that	{A 068}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 068}	Continued From page 5 the contracted laboratory was having computer glitches and that they did not call the hospital with the results because the results were not critical. 5. On 07/16/18 at 2:30 PM, Surveyor #5, a licensed practical nurse (Staff #506), and the Director of Clinical Services (Staff #503) reviewed the medical record of Patient #503 who was admitted on 07/06/18 for the treatment of schizophrenia, psychosis, and auditory/visual, tactile and olfactory hallucinations. The medical record review showed: a. On 07/06/18 at 1:00 PM, staff completed a Dietitian Referral Form for "decreased appetite". A note on the form indicated that the form was faxed on 07/06/18 at 1:00 PM. Surveyor #5 found no evidence in the medical record that the dietitian completed an evaluation of the patient or that the nursing staff received or reviewed the results. 6. At the time of the review, Staff #506 confirmed the finding. 7. On 07/16/18 at 2:35 PM, Staff #503 called the dietician and then reported to Surveyor #5 that the dietician had not received the referral from 07/06/18, and that the referral had not been completed for this patient.	{A 068}		8/9/2018
{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights.	{A 115}	**Cross Reference please refer A 068 and A 144**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 115}	Continued From page 6 This CONDITION is not met as evidenced by: Based on interview and document review, the hospital failed to provide for patient safety and protection of patient rights. Failure to protect and promote each patient's rights risks patients suffering physiological or psychological harm. Findings included: The hospital failed to ensure patients received care in a safe setting which safeguards vulnerable individuals from self-harm . Due to the severity of deficiency under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross Reference: Tags A0144	{A 115}	**A 144 Item #1** **Plan of Correction for Each specific deficiency Cited:** The hospital failed to detect contraband on two adolescent patients. **Procedure/process for implementing the plan of correction:** • RN's, LPN's, and MHT's were retrained by the CNO/ Designee on 5 identified areas including but not limited to the room searches per policy are conducted twice a day to ensure that mitigation plans have taken place for safety of the unit and patients. This occurred on 8-6-2018 through 8-9-2018, prior to working their first shift since the changes. Included in the training process's and implementations: o Intake- Wanding with metal detector has commenced for every patient brought into the facility. Belongings are inventoried and searched for contraband. o Admission-Wanding occurs with a metal detector and belongings Inventoried/searched for any contraband. All items coming in with the patient are closely inspected. A full body search of every patient admitted is part of the screening for contraband. The patient undergoes skin check and inspection of contraband on the body completed at this time. o On Unit- Utensils are carefully monitored by staff. Staff	8/9/2018
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Item #1 - Contraband Based on interview, record review, and review of hospital policy and procedures, the hospital staff failed to implement its policies and procedures for patient safety checks to prevent contraband from entering the facility.	{A 144}		

complete an inventory of utensils when handed out and patients with utensils are within view of staff. Additional mitigation for any hidden contraband includes conducting room searches of every room, This includes looking in patient belongings in their room. Patients suspected of having hidden contraband will be searched on person for any contraband when returning from the cafe, and a full body search is conducted by provider order of any patient believed hiding contraband after being off unit.

- Cafeteria- Utensils are monitored and inventoried when returned after meals to ensure the utensil is whole when returned to safe guard against any type of contraband returning to the unit. A designated staff person stands by at the garbage receptacle to ensure patients do not attempt to remove an item of contraband. A staff person is always during meals and conducts rounds close to the patients during meals in the cafeteria to ensure no self-harming behavior or hiding of contraband occurs.
- Visits- All visitors are wanded with a metal detector prior to leaving the lobby to ensure contraband is not being smuggled in. Belongings brought in by visitors are searched. Security personnel are present for visiting hours to ensure no contraband items are being handed off. If it is known that a visitor has given contraband to a patient, the treatment team and provider are to determine if the visitor will no longer be allowed to visit, or if visiting is restricted.
- Twice a day room searches of all rooms are conducted to

ensure for a second time that no contraband is missed.

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

- Any contraband found is reported in an incident report and an investigation is conducted.
- Monthly staff meetings take place to ensure communication to the staff of compliance. This took place on 7/31/18 and 8/1/18 at three separate times on a monthly basis to ensure communication and compliance.
- All incident reports are reported to senior leadership through the communication process. This includes findings, follow-up and any questioned results by the board.
- Staff who do not follow procedure are held accountable through coaching and the disciplinary process.
- A member of the nursing leadership team are to be personally present for At least one the unclothed skin checks depending on admissions and orders, and 10% of room searches weekly.
- Staff who fail to follow the correct procedure will receive disciplinary action, up to and including termination.
- Audits 5 days a week conducted to include:
    - Admission belongings inspections to ensure staff compliance with CAP
    - 5 meals weekly in cafeteria to ensure staff compliance with CAP
    - At least 2 family visitations weekly in cafeteria to ensure compliance with CAP.

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

- The CNO/designee will issue monthly reports of compliance to the Performance Improvement Committee

			then communicated to the Governing board monthly. • The CNO presents the data at the PI committee resulting numbers and ensures a new corrective action plan is complete if the compliance drops below 80% for 2 continuous months. The audit is ongoing until 90% monthly compliance rating is achieved for 3 continuous months. **Individual Responsible:** • CNO/ Designee **Date Completed:** 8/9/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 7 Failure to detect and prevent contraband and other hazardous items from entering or being available in the hospital risks patient, visitor, and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Unclothed Body Search/Property Search," no policy number - revised 06/18, showed that personal possessions are searched on admission and as clinically indicated to ensure a safe environment for all patients. Upon admission, all personal possessions will be searched to prevent the entry of sharps or contraband into the patient area. The hospital either will secure restricted items in the patient's cubicle or will send the items home. Upon admission to the hospital, staff will conduct an unclothed body search. Hospital staff can execute a room search for contraband consistent with unit guidelines and if directed by the patient's physician. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number - revised 06/18, showed that the hospital performs room searches twice a day and as indicated for patient and staff safety. Patients shall not keep cigarettes, cigars, or pipes in their possession. The hospital listed bras as a common hiding place for cigarettes. 2. On 07/16/18 at 9:10 AM, Surveyor #3 interviewed a mental health technician (Staff #301) about room searches and retrieval of patients' personal items. Staff #301 stated that room searches are conducted every shift. The	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 8 surveyor asked the staff member how Patient #301 was able to bring "vape pens" into the hospital without being detected. Staff #301 stated that her understanding was that the patient hid the items in her bra and that the patient did not remove her bra during the admission body and safety search. 3. On 07/16/18 at 1:15 PM, Surveyor #3 reviewed the medical record of Patient #301. The medical record showed: Patient #301 was admitted to the hospital on 06/21/18 with major depressive disorder. The hospital placed the patient on suicide observational checks every 5 minutes as she was evaluated as high risk for suicide. The initial nursing assessment and admission data form dated 06/21/18 showed that the nursing staff performed a body and safety search upon admission. A psychiatric progress note dated 07/15/18 at 1:40 PM showed that on 07/14/18, a search of the patient's room revealed vape pens. The patient stated she had them in her bra when she first arrived to the hospital. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 06/07/18 Item #2 - Safe from Self-Harm: 1 to 1 Monitoring Based on record review, and review of hospital policy and procedure, the hospital failed to develop and implement a system to ensure the safety of 1 of 1 patients (Patient #302) who had been placed on suicide precautions and one-to-	{A 144}	**A 144 Item #2 and #3 Plan of Correction for Each specific deficiency Cited:** The hospital failed to notify the provider or increase the level of observation on a patient who was making statements of suicidal ideation. **Procedure/process for implementing the plan of correction:** • RN's, LPN's, and MHT's were re-educated by nursing leadership CNO and Designee on 8-6-2018 to 8-9-2018or before working their first shift since the changes in process, regarding how to recognize and report a change in the patient's condition. • Mental Health Techs have been retrained to immediately report any change in the patient's condition to the Registered Nurse, who will immediately assess the patient and notify the provider and document that notification. • The RN will place the patient on the correct precaution immediately, and does not wait for an order from the provider; only the provider can take the patient off precautions. • Staff were re-educated on 8-6-18 to 8-9-18 and prior to working their first shift since the changes were implemented: o Conducting a suicide risk assessment upon being made aware of written, statements, journals entries of self harm, or intentions of self harm. o Notifying the provider on call or attending if available, of the increase in precautions by a nurse, and the justification for the increase in precautions. o Document: the event or behavior, increase the level of observation and precaution depending on suicide risk	8/9/2018

assessment. Documenting the provider response when notified, adjusting the treatment plan for the treatment team. And documenting the suicide risk assessment.

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

- The CNO/ Designee now monitor at least weekly the Kardex nursing reports of 30% of patients throughout the hospital.
- Charge nurses now notify the CNO/ Designee of any changes in patient condition by the end of their shift.
- The CNO/ Designee will investigate changes in patient condition to ensure that proper action was taken, including notification of the provider and family (if appropriate).
- Audit 5 days a week of at least:
  - The CNO will review all incident reports.
  - Chart audit of at least 10 charts per day for review of change of condition to ensure staff compliance with CAP.

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

- The CNO/designee will issue monthly reports of compliance to the Performance Improvement Committee then communicated to the Governing board monthly.
- The CNO presents the data at the PI committee resulting numbers and ensures a new corrective action plan is complete if the compliance drops below 80% for 2 continuous months. The audit is ongoing until 90% monthly compliance rating is achieved for 3 continuous months.

Individual Responsible:

			• **CNO/** Designee **Date Completed:** 8/9/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 9 one monitoring for being a danger to self. Failure to protect patients from self-harm and harm to other patients and staff members, poses a serious threat to the health and safety of all patients and staff, which could result in serious injury and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Levels," effective date 05/17, showed that patients placed on one-to- one monitoring require that staff accompany the patient and stay within reaching distance at all times. This includes while the patient performs personal hygiene, toileting, and other self-care needs. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/17, showed that one-to-one monitoring is a level of precaution used for patients who represent an active suicide risk. Staff have no other duties or responsibilities other than the one-to-one supervision of the patient. 2. On 07/16/18 at 3:00 PM, Surveyor #3 reviewed the medical record of Patient #302. The medical record showed: Patient #301 was admitted to the hospital on 05/14/18 with major depressive disorder with suicide attempt. On 06/29/18, Patient #302 was on Suicide and Self-Harm precautions with Line of Sight monitoring.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3956 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 10 A nursing day shift progress note written on 06/29/18 at 1:45 PM showed the patient's status increased from Line of Sight Monitoring to One-to-One monitoring after stealing a fork at breakfast and hiding it in his waistband. On 07/11/18, a physician psychiatric note showed Patient #302 continued to self-harm. The progress note stated, "Yesterday staff found a sharp utensil piece in his mouth and today (there was a utensil piece) in his laundry". On 07/12/18, a nursing day shift progress note showed that Patient #302 informed a mental health technician that he had swallowed a small piece of plastic. The nurse notified the physician of the incident. On 07/12/18, a physician psychiatric note showed that Patient #302 continued on one-to-one monitoring and admitted to swallowing a small plastic item. The note also showed the patient was self-harming in the morning. On 07/13/18, a physician psychiatric note showed that Patient #302 continued on one-to-one monitoring. The note also showed that there have been episodes of "sneaky behavior" by Patient #302 with the patient attempting to take broken pieces of plastic utensils last evening. Staff put the patient into hospital scrubs and performed a room search. On 07/14/18, a physician wrote an order that the patient could only have finger foods. 3. On 07/17/18 at 9:40 AM, Surveyor #3 interviewed the Assistant Chief Nursing Officer (ACNO) (Staff #302) about suicide precautions	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 11 and one-to one monitoring. The surveyor asked the ACNO how a patient on one-to-one monitoring could obtain plastic utensils to self-harm. She stated this was a staff performance issue and should not have happened. Item #3 - Suicide Assessment Based on interview, record review, and review of hospital policy and procedures, the hospital staff failed to implement the facility's policy and procedure for suicide assessment and reassessment for 2 of 3 records reviewed (Patient #501 and Patient #301). Failure to assess patients for suicide and failure to communicate patients' risk of self-harm to their providers, posed a serious threat to the health and safety of all patients and staff that could result in serious injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/17, showed that patients will be assessed for suicide risk at least upon admission and at discharge. Additional suicide risk assessment may be conducted for changes in behavior or suspicion of suicidal ideation. Staff will immediately notify the physician/provider for any suicide risk assessment of high or severe. A nurse may place a patient on Suicide or Line of Sight Precautions without prior physician's approval and notifies the attending physician for a written order. 2. On 07/16/18 at 10:00 AM, Surveyor #5 and a	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 12 registered nurse (Staff #502) reviewed the medical record of Patient #501 who was admitted on 07/13/18 at 9:00 AM for the treatment of suicidal ideation with a plan and intent, psychosis, and bipolar depression. The patient had a history of prior suicide attempts by overdosing and slitting her wrists. The medical record review showed: The High Risk Notification Alert form signed on 07/13/18 prior to the patient's arrival by the admitting provider, admission staff and the unit nurse receiving hand-off report showed that patient #501 was a high risk for suicide. The Initial Nursing Assessment and Admission Data form showed that the patient arrived to the department on 07/13/16 at 9:00 AM with the chief complaint of suicidal thoughts and hallucinations. The Intake Assessment form completed on 07/13/16 at 9:18 AM showed that the patient was high risk for suicide with suicidal ideation, including a communicated plan and had high intent. The document showed that the patient was admitted to the hospital for inpatient treatment with suicidal precautions. On 07/13/18 at 8:00 AM, the Patient Behavior Record showed that the patient was under every 15-minute observations, but did not receive every 5-minute monitoring for suicide precautions until 2:00 PM on the same day (an elapsed time of 5 hours). 3. At the time of the medical record review, Staff #502 confirmed the finding and stated that nursing staff receive notification of suicide risk via the "High Risk Notification form" on admission,	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 13 and nurses can place a patient on suicide precautions based on assessment or change in status without an initial provider order. 4. On 07/16/18 at 3:00 PM, the Chief Nursing Officer (Staff #501) verified the patient was not placed on suicide precaution monitoring for the first five hours of admission and stated that the patient should have been placed on suicide monitoring upon admission at 9:00 AM. 5. On 07/16/18 at 1:15 PM, Surveyor #3 reviewed the medical record of Patient #301, who was admitted to the hospital on 06/21/18 with major depressive disorder. The medical record showed: The hospital placed the patient on suicide observational checks every 5 minutes consistent with an evaluation as "high risk" for suicide. The patient's condition improved, and by 07/10/18, Patient #301 was on 15-minute checks and Self-Harm Precautions. On 07/10/18 at 9:30 PM, a mental health technician (Staff #303) wrote an inpatient progress note stating that during a room check, Staff #302 read Patient #301's journal and found notes alluding to killing herself with another patient that was on the unit. In a separate note, Patient #301 listed five separate goals that mention suicide. The notes outlined possible plans for suicide including "slit my wrists", "overdose on Xanax" and "drink bleach". Staff #303 also documented reading notes that showed Patient #301 threatened a therapist and encouraged the therapist to commit suicide. The surveyor found no documentation in the	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 14 medical record to indicate Staff #301 had informed the registered nurse (Staff #304) on duty of her discovery. The surveyor found no documentation in the medical record to indicate the registered nurse on duty (Staff #304) had conducted a suicide risk assessment of Patient #301 at the time of discovery nor had he contacted the physician or provider on-call about the mental health technician's discovery. On 07/11/18 at 12:22 PM, a physician wrote an order changing Patient #301's monitoring and precaution status to suicide precautions, unit restriction, and line of sight precautions. A physician psychiatric progress note dated 07/11/18 at 2:00 PM showed that the hospital had scheduled the patient for discharge prior to the discovery of the journal entries. When the physician confronted the patient the next day, Patient #301 stated, "I'm going to kill myself no matter what". The physician made a referral for the designated crisis responder to evaluate the patient for involuntary treatment. 6. On 07/17/18 at 9:40 AM, Surveyor #3 interviewed the Assistant Chief Nursing Officer (ACNO) (Staff #302) and the Chief Medical Officer (Staff #305) about the events surrounding Patient #301 on 07/10/18. Staff #302 stated that she had spoken with the registered nurse (Staff #304) on duty at the time of the incident. Staff #304 confirmed that the mental health technician had informed him about their discovery. Staff #304 told the ACNO that when he was informed, Patient #301 was already asleep. In the morning, Staff #304 passed information about Patient #301	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 15 to the on-coming day shift nursing staff. Staff #305 stated that she changed the patient's monitoring status upon receiving the information about the found material. Staff #305 and Staff #320 could not find any evidence in the medical record that staff informed the on-call physician of the journal notes the mental health technician discovered. {A 405} ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: ITEM #1 - CIWA Protocol	{A 144}	**A 405 Item #1** The Hospital failed to discontinue the CIWA protocol as ordered resulting in a medication error. **Procedure/process for implementing the plan of correction:** • Medical staff were trained on 7/19/2018 by the Medical Director to include the names of individual medications to be discontinued in the CIWA protocol rather than writing "discontinue all CIWA medications." Including but not limited to o Purpose, Frequency, Scoring, PRN medications, discontinuing medications or protocol. • Nursing staff and pharmacy staff were trained on 8-6-18 to 8-9-18 and prior to working their first shift since changes initiated by the CNO or Asst. CNO to request clarification of any orders that contain "discontinue all CIWA medications." **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The CNO/ Designee will monitor 100% of all CIWA charts daily (5 days a week) to ensure that all orders are written correctly (or clarified) and properly carried out. • Staff who do not properly carry out the orders will receive coaching and disciplinary action up to and including termination. • Audit 5 days a week of all active CIWA/COWS charts. **Process improvement: Address process improvement and demonstrate how the**	8/9/2018

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

- The CNO/designee will issue monthly reports of compliance to the Performance Improvement Committee then communicated to the Governing board monthly.
- The CNO presents the data at the PI committee resulting numbers and ensures a new corrective action plan is complete if the compliance drops below 80% for 2 continuous months. The audit is ongoing until 90% monthly compliance rating is achieved for 3 continuous months.

Individual Responsible:

- CNO/ Designee

Date Completed:
8/9/2018

A405 Item #2 Plan of Correction for Each specific deficiency Cited:

- The hospital failed to follow procedure for checking for allergies resulting in a patient receiving a medication to which he had stated he was allergic. An additional patient received a dose of Librium from the CIWA protocol when it was not time for that medication to be given. Additionally, medications ordered three times daily were given four times daily. Nursing identified a medication error but did not submit a medication error report.

Procedure/process for implementing the plan of correction:

- Nurses were re-educated by the CNO and ASST. CNO on 8-6-18 to 8-9-18 and prior to working their first shift since changes implemented. Regarding not to give medications without a written order and to always check for allergies prior to administering medications.

- The Medication Administration Record (MAR) was revised on 8-2-18 by the Director of Information Technology to be a midnight to midnight form so that all medications given within a day are easily visible on the record. Nursing was re-educated by the CNO and Asst. CNO on 8-6-2018 to 8-9-2018 and prior to working their first shift since the change in the MAR.
- Providers on 7/19/18 and pharmacy at the Pharmacy and Therapeutics Committee on 7/20/18have been educated by the Medical Director on discontinuing medications and listing every single medication in the discontinuation order.
- In order to create a non-punitive culture of safety campaign was started on 8/6/2018 by the CNO to encourage reporting. SPBH has implemented a culture of safety and Just Culture ensuring non- punitive approach to reporting medication errors including a rewards system for the increase in reporting medication errors, variances and adverse reactions. This also includes but not limited to trend medication errors by unit and shift to mobilize resources to units with the highest error rate. This was implemented on 8/9/2018 by the Director of Human Resources and CNO/ CEO.

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

- The CNO monitors sources of potential medication errors to include: pharmacy reports, Pyxis reports, conversations with providers.
- The CNO matches those potential medication error "hints" to medication error reports. Any missing medication error reports are requested, tracked, and reported up through the Pharmacy & Therapeutics Committee and the Performance Improvement Committee.
- Employees who do not follow the proper procedure will be subject to coaching and disciplinary action up to and including termination.

- At least 10 charts per day are reviewed for allergies, medication administration for errors, and ensuring staff compliance with CAP.
- Monthly drawings and recognition of staff reporting medication errors.

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

- The CNO/designee will issue monthly reports of compliance to the Performance Improvement Committee then communicated to the Governing board monthly.
- The CNO presents the data at the PI committee resulting numbers and ensures a new corrective action plan is complete if the compliance drops below 80% for 2 continuous months. The audit is ongoing until 90% monthly compliance rating is achieved for 3 continuous months.

Individual Responsible:

- CNO/Designee
- Director of Pharmacy

Date Completed:
8/9/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 16 Based on interview, record review, and review of policies and procedures, the hospital failed to ensure that nursing staff followed physician 's orders for medication administration for 2 of 4 patients (Patients #1101, and #1102). Failure to administer medications according to physician's orders and hospital policies and procedures places patients at risk for harm due to medication errors. Findings included: 1. Record review of the hospital's policy and procedure titled, "COWS [Clinical Opiate Withdrawal Scale] & CIWA [Clinical Institute Withdrawal Assessment of Alcohol]," no policy number, effective date 06/2018, showed that providers will order use of the CIWA scale to monitor the severity of withdrawal symptoms and guide potential preventative therapy. For a patient who is in or expected to be in withdrawal from alcohol the provider may order medications to be administered according to the symptoms, CIWA score, or both. 2. Review of the medical record of Patient #1101 showed the following: a. A registered nurse received a verbal order on 07/14/18 at 5:00 PM to implement the "Alcohol Detox Protocol". According to the protocol, one of the PRN [as needed] medications, Chlordiazepoxide 50 mg, was to be administered for a CIWA score greater than 8. b. The "Alcohol Assessment Flowsheet" showed Patient #1101 had a CIWA score of 8 at 10:00 AM. The medication administration record (MAR)	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 17 indicated that an RN administered 50 mgs [milligrams] of Chlordiazepoxide. According to the physician's order the patient should only receive the medication for scores greater than 8. c. The MAR indicated that a nurse administered another 50 mgs of Chlordiazepoxide at 8:30 PM. Review of the Alcohol Assessment flowsheet showed that there was no corresponding CIWA score indicating that the patient had a score greater than 8. d. On 07/16/18 at 2:00 PM, Surveyor #11 interviewed the Chief Nursing Officer (Staff #1101) about the results of the record review. The Chief Nursing Officer reviewed the nursing documentation and then stated that he did not know why nurses administered the medications outside the parameters set in the CIWA protocol. 3. Review of the medical record of Patient #1102 showed the following: a. A provider ordered the CIWA Protocol on 07/09/18 at 3:50 PM. The protocol contained orders for both scheduled medications (Gabapentin, Thiamine, Multivitamin and Folate) the patient received every day and PRN [as needed] medications the patient received according to CIWA scoring or patient symptoms. b. On 07/11/18 at 11:40 AM, a provider wrote an order to discontinue the CIWA protocol and all CIWA medications. c. Review of the Medication Administration Record (MAR) showed that nurses continued to administer the scheduled medications in the protocol. On 07/11/18, a nurse administered	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 18 Gabapentin 300 mgs at 2:00 PM and 9:00 PM and Thiamine at 9:00 PM. On 07/12/18, a nurse administered Gabapentin 300 mgs at 9:00 AM, 2:00 PM, and 9:00 PM, a Multivitamin at 9:00 AM, Thiamine at 9:00 AM and 9:00 PM, and Folic Acid at 9:00 AM. On 07/13/2018, a nurse administered Gabapentin 300 mgs at 9:00 AM, a Multivitamin at 9:00 AM, Thiamine at 9:00 AM, and Folic Acid at 9:00 AM. d. On 07/13/18 at 10:45 AM, the provider wrote a clarifying order to discontinue specific medications [Folic Acid, Multivitamin, and Thiamine] and decrease the dosage of Gabapentin from 300 mgs to 100 mgs. On 07/16/18 at 9:45 AM, Surveyor #11 interviewed the registered nurse (RN) (Staff #1102) who administered the medications on 07/12/18. Staff #1102 stated that he did not know why the medications were not discontinued as ordered by the provider on 07/11/18. On 07/16/18 at 10:00 AM, Surveyor #11 interviewed the Director of Pharmacy (Staff #1103). The interview showed that Staff #1103 thought the order to discontinue the CIWA medications was confusing. Staff #1103 stated that he was unsure if the provider wanted to discontinue the scheduled and PRN orders or just the PRN orders. The director of pharmacy stated that he was planning to discuss the issue with providers during the next pharmacy and therapeutics meeting. Item #2- Medication Errors Based on interview, record review, and review of policy and procedure, the hospital failed to ensure	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 19 that nursing staff followed the hospital's policy and procedure for reporting of medication administration errors for 1 of 1 patients reviewed (Patient #1103). Failure to report medication errors limits the hospital's ability to improve medication administration processes and improve patient outcomes. Findings included: 1. Patient #1103 was admitted on 6/26/18 for treatment of bipolar mania. Review of Patient #1103's medical record showed the following: a. The "Allergies Worksheet" completed by nursing upon admission on 6/26/18 showed that the patient had an allergy to several medications including Haldol (an anti-psychotic medication). b. The MAR, dated 07/13/18 through 07/14/18, showed the patient's allergies in the bottom left corner. The patient's allergies included the medication Haldol. c. A nurse documented a verbal order on 07/13/18 at 10:55 AM for Ativan 1 mg PO [by mouth], Haldol 5 mgs PO, and Benadryl 50 mgs PO to be administered "now". d. The MAR, dated 07/13/18 through 07/14/18, showed a nurse administered the Haldol and the other medications at 11:00 AM. e. A nursing note, dated 07/14/18 at 2:55 AM, stated "Pt [patient] received Haldol this AM [morning] despite listed allergy. Provider notified. Order received to watch patient for allergic	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 20 reaction till 8:00 AM." 2. On 07/16/18 at 3:00 PM, Surveyor #11 interviewed the Chief Nursing Officer (Staff #1101) about the results of the record review. The Chief Nursing Officer reviewed the nursing documentation and confirmed the surveyor's findings. 3. Document review of a report completed by the Chief Nursing Officer (Staff #1101) on 07/16/18, the day Surveyor #11 reviewed the patient's medical record, showed that he was notified of the error on 07/13/18 at 8:00 PM and that the nurse administered the medication without checking the MAR for patient allergies prior to administration. Neither the nurse who administered the medication nor the nurse who discovered the medication error completed a Medication Error Incident Report. 4. In the same patient's medical record, a provider wrote an order on 07/11/18 for Lorazepam 1 mg PO [by mouth] three times a day as needed for symptoms of anxiety. 5. Document review of the MARs, dated 07/10/18 at 7:00 AM through 07/16/18 at 6:59 AM, showed that the patient received Lorazepam 1 mg four times per day rather than three times per day on the following days: -07/12/18 7:00 AM to 07/13/18 6:59 AM at 9:00 AM, 2:40 PM, 6:55 PM and 3:25 AM -07/14/18 7:00 AM to 07/15/18 6:59 AM at 9:30 AM, 2:15 PM, 7:58 PM and 4:00 AM	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 07/17/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 405}	Continued From page 21 6. Document review of the charge nurse report on 07/16/18 at 1:20 PM, showed that nursing staff identified the medication error and documented that a system error was the cause of the error. 7. On 07/17/18 at 9:15 AM, Surveyor #11 interviewed the Director of Pharmacy (Staff #1103) about the medication administration error related to the Lorazepam. The Director of Pharmacy reviewed the MARs and confirmed the surveyor's findings. 8. On 07/17/18 at 11:27 AM, Surveyor #11 interviewed the Director of Quality (Staff #1104) about medication error reporting by nursing staff . The Director of Quality stated that staff had not submitted an incident report for the Lorazepam medication error. He stated that staff should have completed a "Medication Error Incident Report" once they discovered the error. 9. Document review of the hospital's policy and procedure titled, "Incident Reports," no policy number, effective date 5/17, showed that the staff member involved or the staff member who witnessed the event must complete an incident report prior to the end of their shift.	{A 405}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE COMPLAINT SURVEY 3rd FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint follow-up survey. Onsite dates: 09/10/18 to 09/12/18 The survey was conducted by: Surveyor #5 Surveyor #11 DOH staff found the facility has substantially corrected all Condition-level deficiencies cited during the 07/16/18 - 07/17/18 hospital complaint survey follow-up visit. During the course of the survey, surveyors assessed issues related to complaint intake #80538 and #84468. DOH staff found the facility in substantial compliance with all Conditions of Participation set forth in 42 CFR, Acute Care Hospitals except those standard-level deficiencies listed below.	A 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 days from the date you receive the Statement of Deficiencies. 4. Return the ORIGINAL REPORT with the required signatures.	
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:]	A 068		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 1 A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the Governing Body failed to develop and maintain an effective system to ensure that physicians monitored and met the patient's nutritional needs for 3 of 4 patients reviewed (Patient #501, #503, and #504). Failure to develop an effective system to provide for patient's nutritional needs risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutrition Screen and Assessment," no policy number, revised date 08/18, showed that nutrition screens would be reviewed and signed by the licensed dietician when requested by the physician or nursing staff. During the nutritional assessment, the dietician would determine the need for a diet change and would make recommendations for a specific diet	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 2 for the patient. These recommendations would be relayed to the attending physician or treatment team as appropriate. 2. During the survey, Surveyor #5 reviewed the records of three patients currently being treated at the hospital and interviewed hospital staff members. The record reviews and interviews showed the following: a. Patient #501: 1) 09/10/18 at 10:20 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Program Director (Staff #504) reviewed the medical record for Patient #501. This patient had been admitted on 05/31/18 for the treatment of Schizophrenia, Secondary Dissociative Disorder, and Command Auditory Hallucinations to harm self. The record review showed the following: a) Patient #501 was referred for a dietary consult on 06/10/18 due to "poor intake." At that time, the dietician's nutritional assessment showed the patient had a 4 pound 2 ounce weight loss in 1 week. The dietician recommended a) a high protein milkshake once daily; b) Ensure® (a nutritional supplement or meal replacement) after each meal when oral intake was less than 50%; and c) to measure and record the patient's weight. b) Nursing documentation on 08/27/2018 and 08/28/2018 showed that the patient continued to have poor dietary intake and was refusing the supplements. c) The dietician completed a nutritional assessment on 08/28/18. The assessment	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 3 showed that Patient #501 had lost 10 pounds since admission. The dietician recommended offering chocolate Ensure® if meal intake was less than 50% and providing a high protein milkshake two times daily. The dietician follow-up plan included a weight check and further discussion with the patient about her intake in one week. There was no evidence in the patient's medical record that showed the dietician completed a follow-up review or weight check concerning the patient's poor dietary intake and weight loss. d) A Psychiatric Progress Note completed on 08/29/18 at 12:00 PM stated, "Sleep and appetite are fair. Continue stabilization and follow up with family services. Continue current milkshakes daily." Surveyor #5 found no evidence the healthcare provider had reviewed the dietician's 08/28/18 recommendation to increase the milkshakes to twice a day. e) Documentation on the Daily Nursing Progress Notes showed that from 08/26/18 through 09/09/18 (a period of 15 days), the patient ate less than 50% of his/her meal for 19 of 41 meals served. There was no documentation in the patient's record that showed the patient received Ensure® when her meal intake was less than 50%. f) On 08/29/18, review of the patient's medication administration record (MAR) showed an order change to increase the high protein milkshake to twice daily. Staff documented the patient received the high protein shake at 9:00 AM and 2:00 PM. The next day, on 08/30/18 the MAR showed the patient was to receive the high protein milkshakes once daily per physician order dated 06/15/18.	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 4 Review of the MAR dated 08/30/18 to 09/10/18 continued to show that the patient order for protein milkshakes was once per day rather than twice per day as recommended by the dietician. 2) On 09/10/18 at 12:00 PM, during an interview with Surveyor #5, the Dietician (Staff #506) stated that a provider did not need to write a diet order and that the dietician consultation was enough. The dietician was unaware of the revised nutritional assessment and screening procedure that stated the dietician only made recommendations for diet orders. She stated that Patient #501 should be receiving the high protein shakes twice daily. She stated that she did not know if the patient was receiving the Ensure® supplements and she did not know where staff documented how much of the dietary supplement the patient consumed. The dietician confirmed she had not followed up with the patient nor weighed the patient per the nutrition consultation plan. She verified there were no other weights documented. At the time of the interview, the dietician did not know if the patient was gaining or losing weight. 3) On 09/10/18 at 12:15 PM, during an interview with Surveyor #5, the Program Director (Staff #508) verified the instances of meal intake less than 50% and confirmed there was no documentation of the Ensure® supplements. She verified there were no documented weights on the "neurological/vital signs check/weights" flow sheet. She stated there were no weights documented because the only provider order was to take the patient's weight once on admission (05/31/18). She stated that although the dietician made a recommendation for the high protein shakes twice daily for weight loss, the provider	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 5 must write an order. She stated because the provider did not write an order, the patient should not have received the high protein shake twice on 08/29/18 and the correct order was the order written by the provider on 06/15/18. 4) On 09/10/18 at 12:50 PM, a Licensed Practical Nurse (Staff #507), stated that the high protein drinks and the Ensure® supplements were to be documented either on the MAR or in a nursing progress note. Surveyor #5 found no evidence staff offered or documented the Ensure® supplements. Surveyor #5 questioned Staff #507 about the missing documentation in Patient #501's medical record. Staff #507 stated that there was no standardized process for documenting administration of dietary supplements. b. Patient #503: 1) On 09/11/18 at 11:40 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #510) reviewed the medical record for Patient #503. This patient had been admitted on 09/07/18 for the treatment of suicidal ideation and suicide attempt. The record review showed the following: a) A Laboratory report for a complete blood count collected on 09/07/18 showed that the patient's triglyceride level was 100 mg/dL (high). The lab reference showed 0-89 mg/dL as normal. b) On 09/09/18 at 11:30 AM, a healthcare provider (Staff #511) wrote an order for a dietary consult for diet modification related to elevated triglycerides. c) On 09/10/18 at 11:19 AM, the dietician (Staff	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 6 #506) completed a dietary consultation and documented the consult on a "Nutrition Assessment Form." The dietician recommended a fasting triglyceride lab test to assure the correct level and to start a heart healthy meal plan. 2) On 9/11/18 at 12:00 PM, Surveyor #5 asked a registered nurse (RN) (Staff #510) if the provider had reviewed the recommendations from the dietician. The RN stated she did not know if the provider had reviewed the consultation and verified there was no documentation in the chart to confirm the provider had reviewed the dietary consult. c. Patient #504: 1) On 09/12/18 at 9:22 AM, Surveyor #5, the Senior Clinical Vice-President of Compliance (Staff #501), and a Registered Nurse (RN) (Staff #512) reviewed the medical record for Patient #504 who was admitted on 08/12/18 for the treatment psychosis, depression and suicidal ideation. The record review showed the following: a) On 08/12/18 at 5:50 PM, the admitting healthcare provider ordered a dietary consult. b) The Psychiatric Evaluation completed on 08/13/18 at 11:00 AM showed that the patient's mother reported the patient had decreased appetite and had lost 20 pounds over the past month. The healthcare provider wrote an order for a dietary consult for gluten-free diet due to a weight loss of plus or minus 20 pounds in plus or minus one month. d) The dietician completed the consultation on 08/14/18 at 2:20 PM. The dietician noted in the	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 7 assessment that the patient has lost plus or minus 20 pounds in the past month and reported lab values that showed a low total protein level of 5.9 (Normal range 6.0 to 8.3 grams per deciliter (g/dL). The dietician recommended nutritional supplements to optimize caloric and protein intake, and recommended high-protein nutritional milkshakes two times daily at 10:00 AM and 2:00 PM. e) On 09/04/18 at 10:00 AM, a healthcare provider wrote an order to discontinue the protein shakes. Surveyor #5 found no evidence a provider had ordered the high protein shakes. The Registered Nurse (RN) (Staff #512) stated that the patient was not receiving high protein shakes. f) Documentation showed one patient weight taken on admission to the hospital. 2) On 09/12/18 at 9:40 AM, Surveyor #5 asked the Senior Clinical Vice-President of Compliance (Staff #501) if the provider had reviewed the dietician consultation and recommendations. Staff stated that she did not know, and after review of the documentation, confirmed there was no way for staff to identify if the provider reviewed the dietary consultation. At this time, she confirmed there was no provider order for high protein shakes, and staff had not weighed the patient since admission. 3) On 09/12/18 at 10:00 AM, Surveyor #5 reviewed the medical record a second time with a dietician (Staff #506) and the Chief Nursing Officer (Staff #502). Surveyor #5, Staff #506 and Staff #502 discussed the patient's "fair" meal intake noting the patient's meal intake ranged	A 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 068	Continued From page 8 from 0% to 100%, but averaged around 50%. Staff #502 stated that it appeared that the patient had decreased intake around times of worsening psychological status. At this time, the dietician (Staff #506) stated that she did not know if the patient received the high protein shakes or not, and she did not know if the provider ordered the high protein shakes. Surveyor #5 asked Staff #502 how she communicated a patient's nutritional status or nutrition concerns and if she attended the patients treatment team meetings. Staff #502 stated she did not attend the treatment team meetings, but that sometimes she would ask providers to write orders when she saw them.	A 068		
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure hospital staff members followed the policy and procedure for patient safety checks for 1 of 2 occurrences reviewed. Specifically, hospital staff members did not complete an incident report when contraband was found in a patient's room, and hospital administration did not investigate how the contraband was brought into the hospital Failure to report, investigate, and prevent contraband and other hazardous items from being brought into the hospital risks patient, visitor, and staff injury. Findings included:	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 9 1. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number, revised date 06/18, showed that hospital staff members would search patient rooms for contraband at least twice daily. Contraband included prohibited items such as illegal drugs and paraphernalia. The policy showed that when staff discovered contraband, hospital staff would confiscate the items; immediately notify the patient, the patient's healthcare provider, and the Chief Nursing Officer; and complete an incident report. 2. On 09/11/18, Surveyor #5 reviewed the medical record for discharged Patient #502 who had been admitted on 08/04/18 for the treatment of psychosis and schizophrenia. The record review showed that on 08/06/18 at 4:21 PM a healthcare provider ordered a urine drug screen. On 08/07/18 at 5:00 AM, the urine drug screen showed a positive result for methamphetamine. A "Daily Nursing Progress Note" dated 08/07/18 showed that on at 1:00 PM staff discovered a syringe filled with black fluid in the patient's room during a routine room search. 3. On 09/11/18 9:00 AM, Surveyor #10 reviewed the hospitals incident report log. Surveyor #10 found no evidence that staff had completed an incident report following the event above. Surveyor #10 found no evidence that the hospital conducted an investigation of the incident. 4. On 09/11/18 at 9:30 AM, Surveyor #5 and Surveyor #10 discussed the finding with the Director of Process Improvement and Risk (Staff #505). Staff #505 stated there were no incident reports related to contraband in August 2018. He	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 10 stated he was "aware" of the incident, but could not locate an incident report. 5. On 09/11/18 at 11:05 AM during interview with Surveyor #5, a Registered Nurse (RN) (Staff #514) stated that the staff conducted contraband checks twice daily, once on day shift and once on night shift. The RN stated that a Licensed Practical Nurse (LPN) (Staff #507) and a Mental Health Technician (MHT) (Staff #513) told him about the syringe of methamphetamine after they found it under a mattress in the patient's room on 08/07/18. He stated the LPN and the MHT disposed of the syringe. He stated that he went to the office of Staff #502 and reported the incident. He stated he remembered going to her office, as he was feeling "panicky because (he) had never had this happen before and (he) needed guidance." He stated that Staff #502 told him to document the incident in the chart. He stated he did not remember if he completed an incident report. He stated he asked the patient how she got the methamphetamine the patient stated that she did not want to talk about it. 6. On 09/11/18 at 11:29 AM, Surveyor #5 interviewed the hospital's Chief Nursing Officer (CNO) (Staff #502). Staff #502 stated that she was aware of the incident, but could not recall talking with Staff #514 in her office or recall the outcome of the incident. She stated that at the time of the incident, she was working as the Director of Infection Prevention and Education, not as the hospital's CNO. 7. On 09/11/18 at 1:00 PM, Staff #505 presented Surveyor #5 and Surveyor #10 with an incident report completed that day by the MHT (Staff #513) who found the syringe.	{A 144}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	R-C 09/12/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 144}	Continued From page 11 8. On 09/11/18 at 1:35 PM, Surveyor #5 interviewed Staff #513 regarding contraband, room searches, body searches, and the incident report process. Staff #513 stated that staff conducted contraband checks twice daily, once on day shift and once on night shift. Staff #513 told the Surveyor that when he found the contraband he reported the incident to the charge nurse and the Chief Nursing Officer. Surveyor #5 asked Staff #513 if he filled out an incident report at the time of the incident and he stated he did not remember if he filled one	{A 144}		