FLIER  ORAL HOSPITAL  MMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)		TIPLE CONSTRUCTION  NG  STREET ADDRESS, CITY, STATE, ZIP C  3955 156TH ST NE  MARYSVILLE, WA 98271	(X3) DATE SU COMPLET R-C 07/17/	TED
PLIER  ORAL HOSPITAL  MMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FILL	ID PREFI)	STREET ADDRESS, CITY, STATE, ZIP C 3955 156TH ST NE	07/17/	
ORAL HOSPITAL  MMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FILL	PREFIX	3955 156TH ST NE	07/17/	/2018
MMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FILL	PREFIX	3955 156TH ST NE	ODE	
MMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FILL	PREFIX			
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EFICIENCY MUST BE PRECEDED BY FILL	PREFIX			
TON TON ESO IDENTIFY TING INFORMATION)	TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT)	ORRECTION ON SHOULD BE	(X5)
		CROSS-REFERENCED TO TH	HE APPROPRIATE	OMPLETIO DATE
		DEFICIENCY	2	
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CORADI AIRIT OLIMA (MA			CIOIIIA	
VICIT SURVEY 2nd	1	July alar	811111	
VI311		ナール・ナー	10111	
on State Department of Hoolth		100 pc	XIV Z	
rdance with Medicare Conditions of	ĺ	100	, 01 /M	
et forth in 42 CFR 482, conducted			*	
safety complaint follow-up survey		~ N/0.	0	
		1381		
)7/16/18 to 07/17/18				
: 79682				
s conducted by:	ĺ		İ	
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up survey resulted from a			ļ	
y in which the facility was found	Ì			
JANCE with Medicare Conditions				
set forth in 42 CFR Part 482.				
ten vinte Duncture		i		
that the facility remains at Norwal			į	
with the following Modicage	į			
articipation set forth in 42 CER				
property obtains 42 of IV				
			. ]	
Governing Body		1		
Patient's Rights	1			
	Ì			
DDY	{A 043}			
		<u> </u> 		
affertive governing had the				
·	1			
ER/SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>			
11.			(X6) DATE	
() asterisk (*) denotes a distriction with the	دا//	<u> </u>		
ection to the patients. (See instructions.) Exce	ารบันนังก may be ex ept for nursing home	cused from correcting providing it is determ	lined that	<u>-</u>
not a plan of correction is provided. For nursin	ig homes, the above	indings and plans of correction are disclosables	e 90 days	
Country to the country of the countr	complaint survey 2nd VISIT ton State Department of Health ordance with Medicare Conditions of set forth in 42 CFR 482, conducted disafety complaint follow-up survey.  07/16/18 to 07/17/18  179682  18 conducted by:  19 survey resulted from a set forth in 42 CFR Part 482.  19 set forth in 42 CFR Part 482.  10 set forth in 42 CFR  10 set forth in 42 CFR  11 set of set forth in 42 CFR  12 set of set forth in 42 CFR  13 set forth in 42 CFR  14 set of set forth in 42 CFR  15 set of set forth in 42 CFR  16 set of set forth in 42 CFR  17 set of set forth in 42 CFR  18 set of set forth in 42 CFR  19 set of set forth in 42 CFR  19 set of set forth in 42 CFR  10 set of set forth in 42 CFR  11 set of set forth in 42 CFR  12 set of set forth in 42 CFR  13 set of set forth in 42 CFR  14 set of set forth in 42 CFR  15 set of set forth in 42 CFR  16 set of set forth in 42 CFR  17 set of set forth in 42 CFR  18 set of set forth in 42 CFR  19 set of set forth in 42 CFR  19 set of set forth in 42 CFR  10 set of set forth in 42 CFR  11 set of set forth in 42 CFR  12 set of set forth in 42 CFR  13 set of set forth in 42 CFR  14 set of set forth in 42 CFR  15 set of set forth in 42 CFR  16 set of set forth in 42 CFR  17 set of set forth in 42 CFR  18 set of set forth in 42 CFR  19 set of set forth in 42 CFR  10 set of set fo	COMPLAINT SURVEY 2nd VISIT  Ion State Department of Health Ordance with Medicare Conditions of Set forth in 42 CFR 482, conducted It safety complaint follow-up survey.  O7/16/18 to 07/17/18  T9682  Is conducted by:	COMPLAINT SURVEY 2nd VISIT  Ion State Department of Health rordance with Medicare Conditions of set forth in 42 CFR 482, conducted d safety complaint follow-up survey.  07/16/18 to 07/17/18 : 79682 sis conducted by:	COMPLAINT SURVEY 2nd VISIT  Ion State Department of Health produce with Medicare Conditions of tel forth in 42 CFR 482, conducted d safety complaint follow-up survey.  07/16/18 to 07/17/18 : 79682 as conducted by:

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		504012	B. WING		1	R-C
NAME OF F	PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE		/17/2018
OHOVEY	SOUT SPILLIONAL III			3955 156TH ST NE		
	POINT BEHAVIORAL HO			MARYSVILLE, WA 98271		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO	٧	(X5)
TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	COMPLETION DATE
				A 043 Plan of Correction for Each sp	ecific	8/9/2018
{A U43}	Continued From page		{A 04	21 deficiency Cited:		
	legally responsible for	the conduct of the hospital.	•	THE TIPSTILL ISHED TO DIOVIDE SHECTIVE		
	if a hospital does not	have an organized		oversight to prevent substandard		[
	governing body, the p	ersons legally responsible		practices for patient safety, and patier	t	ļ .
ĺ	for the conduct of the	hospital must carry out the		rights, resulted in an unsafe environm	ent	
	functions specified in governing body	this part that pertain to the		for patients.		
	This CONDITION is no	ot met as evidenced by:		Procedure/process for implementing	the plan	
	•	or and the control of		of correction:		
	Based on document re	eview, medical record		SPBH Governing Board provide	es over	
	review and interview t	he hospital's governing		sight to this Plan of Correction	for the	
	body failed to provide	effective oversight of the		findings of the follow-up survey	by:	
	hospital.	cucoute ateraignt of the		<ul> <li>Reviewing the plan of</li> </ul>	·	
ļ	roopital.		1	Correction to assure t	he	
	Failure to provide effec	tive oversight to prevent	1 '	corrective action for		•
Ì,	substandard practices	for patient cafety, and		deficiencies are clinic	ally	1
	nationt rights resulted	in an unsafe environment		indicated and respons	ive to	
1;	for patients.	in an unsale environment		the Conditions of Part	cipation	
'	or patients.			cited; are sufficient to	prevent	
	Findings included:			recurrence of the defi-	lencies;	
] '	rmaniga iriciuded;			to make certain patier	ts' rights	
	Thomas dans test est.		-	are protected and pati	ents are	
	Observations, interview	s, record reviews, and		receiving appropriate	care with	
1	eview of hospital polici showed the following:	es and procedures,		positive outcomes.		
Ì	•	-		Monitoring and Tracking procedures	0	1
1	. The hospital failed to	ensure patients received		ensure the plan of correction is effect	ve:	
ti	mely results for labora	tory tests and dietary	}	<ul> <li>The Governing Board will receive</li> </ul>	re l	
	onsultations during the			communication from the CEO of	f SPBH	
	g iii		1	on a monthly basis as to monito	ring and	
lo	ross Reference: A006	8	]	evaluation of actions taken and	review	
-		•	Ī	the statistical results of the ongo	ing	ĺ
12	The hospital failed to	provide for patient safety	]	QAPI reporting and make		
	nd protection from self			recommendations as needed.  Process improvement: Address proce		
ا ا	proteodron nom sen	TISATIA		improvement and demonstrate how the	55	. [
	ross Reference: A011	<b>x</b>		facility has incorporated improvement	<u> </u>	
0	ross izelelelice. AUTT	J		actions into its Quality Assessment ar	d	-
_	natatha accedered	Salara		Performance Improvement (QAPI) pro	rem	
1 10	ue to the severity of de	eficiency under 42 CFR		Address improvement in systems to p	event	İ
	32.12, the Condition of			the likelihood of re-occurrence of the	-T-111	ĺ
G	overning Body was NO	) I MET.		deficient practice:		ſ
4 <del>GMB 2667(02</del>	-99) Pravious Versions Obsolute	Event ID: Westure		member representative of the		ſ
		esquiries republication of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contr		um) nor or	ion sheet Pa	19e 2 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 07/23/201 FORM APPROVEI			
CENTERS FOR MEDICARE & MEDICAID SERVICES	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	-0391		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		504012	B. WING	(A) (A) (A) (A) (A) (A) (A) (A) (A) (A)	1	R-C
NAME OF D	PROVIDER OR SUPPLIER	007072	D. WING _		07	7/17/2018
MUNICUTE CITY	NO VIDER ON SOFFEICH			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
SMOKEY	POINT BEHAVIORAL H	OSPITAL		3955 156TH ST NE		
	777774			MARYSVILLE, WA 98271		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{A 043}	Continued From page	e 2	{A 04	3) A 068 Plan of Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction for Eader Correction fo		8/9/2018
{A 068}	CARE OF PATIENTS	- RESPONSIBILITY FOR	{A 06			
-	CARE		1 2.00	Procedure/process for implem	antina tha wlan	
	CFR(s): 482.12(c)(4)		}	of correction:	enting the plan	-
ĺ	( ) ( ) ( )			<ul> <li>A Kardex system has be</li> </ul>	en	
1	[the governing body	y must ensure that the		implemented on units to	track lah	
	following requirement			orders and results, dieta	rv consults.	
į	A doctor of medicine of	or osteopathy is responsible	-	and many other patient	orders and	
	for the care of each M	edicare patient with respect	1	activities. The Kardex sy	stem now is	
	to any medical or psyc	chiatric problem that		the source document for	nursing shift	
	(i) Is present on admi-	ssion or develops during		report. Nurses use the I	Kardex to track	
	hospitalization; and		1	labs, consults, x-rays, of	f site doctor	
	(ii) Is not specifically w	ithin the scope of practice.		visits, precautions, allerg	jies, and more.	
	of a doctor of dental s	urgery, dental medicine,	•	<ul> <li>If STAT labs are ordered</li> </ul>	, the patient is	
	podiatric medicine, or	optometry; a chiropractor;	-	sent out to the ER for the		
}	or clinical psychologis	t, as that scope is		<ul> <li>Nurses were trained on the</li> </ul>	the ability to go	
	(A) Defined by the			online, login and check f	or any lab	
	(B) Permitted by S			results pending on 8-6-2	018 to 8-9-	
	(C) Limited, under	paragraph (c)(1)(v) of this		2018 or before their first	shift worked.	
. ]	section, with respect to	chiropractors.		A downtime policy development	oped by both	1
.	This OTANDADD :		į	the contracting lab comp was created to eliminate	any and SPBH	
	ON SI CHACUNATO SILL	t met as evidenced by:		when a situation occurs y	any cowntime	
	Basad on Interview re-	cord review, and review of		servers are not available	Milesi nie iab	
	inspital policies and p	rocedures the Governing		Nurses were re-educated		
ļ	Body failed to develop	and maintain effective		Designee on 8-6-18 to 8-	9-18 or before	
	systems that ensured t		1	working their first shift fol	lowing the	
	usality healthcare that	met their needs in a safe	İ	changes.	oung the	1
-	environment for 2 of 5	patients reviewed (Patient		Dietary Consults: The pol	licy and	
	#502 and #503).	patiento reviewed (Fatterit		procedure "Nutritional Sc	reen and	-
				Assessment 5/17 has been	en revised to	1
F	allure to provide patie	nts with medical services		include "A dietician Consi	ult Form" #4	}
ti	hat meet the patient's I	healthcare needs in a safe		page 1 of 1 will be comple	eted for each	
е	nvironment risks deter	foration of the patient's		patient admitted. The form	n will indicate	
c	ondition and poor heal	theare outcomes.		if the patient does or does	not require a	
				dietician consult.		
F	indings included:	Ì		<ul> <li>Nurses were educated on</li> </ul>	8-6-18 to 8-	
	<del>-</del>	}		9-18 or before working the	eir first shift	1
MCMC 2567/05	2-00) Denydau'n Marelenn Oberleh		·	following the changes, by	the CNO/	

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 07/23/20
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVE
	OMB NO. 0938-039  Designee regarding the changes in
	process and the new policy.
	Monitoring and Tracking procedures to
·	ensure the plan of correction is effective:
	<ul> <li>Nursing now audits at least 10 charts</li> </ul>
	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:
	<ul> <li>The CNO/designee will issue monthly</li> </ul>
	reports of compliance to the
	Performance Improvement Committee
	then communicated to the Governing
	board monthly.
	- • - The GNO presents the data at the P!
	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/Daring
	CNO/Designee
	Date Completed:
	8/9/2018
	3707.20 (0
·	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
		504012	B. WING _			R-C
NAME OF PROVIDER OF SMOKEY POINT BE		OSPITAL		STREET ADDRESS, CITY, STATE, ZIP CO 3966 156TH ST NE MARYSVILLE, WA 98271	DE	07/17/2018
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOULD BE	(X5) COMPLETION DATE:
1. Docum procedur number, (immedia be availa hours of indraw by the draw draw draw draw draw draw draw draw	e titled, "Lab effective date tely, without ble from the landification of the hospital." It review of the titled, "Nutral no policy nuat nutritional ays of received for 16/18 at 9:18 for O7/13/18 for and suicidal itted from an eated for a semia (low sodum level of 1 amol/L). The lake Call sheet dmission on adium needs odium is 128, drawn". The pleted on 07/lient's sodium is 13/18 at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 leafs at 4:08 lea	of the hospital's policy and oratory Services," no policy to 05/17, showed that STAT delay) laboratory results will lab via phone or fax within 4 if the need for a STAT lab the hospital's policy and itional Assessment laboratory results will be completed ling an order for a nutrition.  5 AM, Surveyor #5 and the vices (Staff #503) reviewed Patient #502, who was or the treatment of all ideation. The patient had emergency room where suicide attempt and itum in the blood) with a 25 mmol/L (normal range medical record review let completed prior to the 07/12/18 at 4:00 PM to be in range, and then rewill call tomorrow after a nurse-to-nurse report 13/18 at 2:30 PM, showed in was less than 130 PM, the hospital's red that clinical staff	{A 06	58)		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED			
		504012	B, WING		1	R-C	
NAME OF	PROVIDER OR SUPPLIER		1	Sì	TREET ADDRESS, CITY, STATE, ZIP CODE	07	7/17/2018
SMOKE	Y POINT BEHAVIORAL HO	OSPITAL .		39	955 156TH ST NE IARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		: VTE	(X6) COMPLETION DATE
{A 068	placed the patient on and ordered a Compr lab test that includes a levels). Surveyor #5 for	a 1,000 cc fluid restriction ehensive Metabollc Panel (a a test of blood sodium	· {A 00	68}		,	
	STAT (immediate, with Panel (a lab test that it sodium levels). Surve	PM, a provider ordered a nout delay) Basic Metabolic includes a test of blood yor #5 found no evidence staff received or reviewed					
	charge nurse (Staff #5 unaware that the hosp results. She stated tha	edical record review, the 02) stated that she was ital had not received the t she had just completed s unaware of the process sts.					
	used for communicatio Neither Surveyor #5 or the staff were aware of	STAT lab results had not					
	At this same time, the I Services (Staff #503) a Preventionist/Educator finding and began their missing test results.	nd the Infection (Staff #504) confirmed the					
	Officer (Staff #505) pres "Computer Downtime L Basic Metabolic Panel t	PM, the Chief Executive sented Surveyor #5 with a ab Results" form with the est results from 07/14/18 rm. Staff #505 stated that					

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		504012	B. WING		R-C
	F PROVIDER OR SUPPLIER EY POINT BEHAVIORAL HO	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH ST NE MARYSVILLE, WA 98271	07/17/2018
(X4) II PREFI TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE COMPLETION
{A 06	the contracted laborar glitches and that they the results because the 5. On 07/16/18 at 2:30 licensed practical nurse Director of Clinical Set he medical record of admitted on 07/08/18 schizophrenia, psychotactile and olfactory has record review showed:  a. On 07/06/18 at 1:00 Dietitian Referral Form	tory was having computer did not call the hospital with the results were not critical.  DPM, Surveyor #5, a se (Staff #506), and the rvices (Staff #503) reviewed Patient #503 who was for the treatment of sis, and auditory/visual, allucinations. The medical :	{A 06	58)	8/9/2018
	A note on the form indifaxed on 07/06/18 at 1 no evidence in the medicitian completed an that the nursing staff results.  6. At the time of the revithe finding.  7. On 07/16/18 at 2:35 dietician and then report	icated that the form was :00 PM. Surveyor #5 found dical record that the evaluation of the patient or eceived or reviewed the riew, Staff #506 confirmed PM, Staff #503 called the ried to Surveyor #5 that			
{A 115}	the dietician had not red 07/06/18, and that the r completed for this patie PATIENT RIGHTS CFR(s): 482.13	ceived the referral from eferral had not been	{A 115		
	A hospital must protect a patient's rights.	and promote each		Cross Reference please refer A 068 and	<u>A 144</u>

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		504012	B. WING		R-C	
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{A 118	Continued From page	6	JA 11	63	8/9/2018	
	This CONDITION is n . Based on interview ar	ot met as evidenced by: nd document review, the de for patient safety and	VA 11	A 144 Item #1  Plan of Correction for Each specific deficiency Cited:  The hospital failed to detect contraband adolescent patients.	on two	
	Failure to protect and prights risks patients surpsychological harm.  Findings included:  The hospital failed to ecare in a safe setting would be understood to the severity of communication.	promote each patient's ffering physiological or ensure patients received which safeguards from self-harm. deficiency under 42 CFR of Participation for Patient		Procedure/process for implementing of correction:  RN's, LPN's, and MHT's were by the CNO/ Designee on 5 ide areas including but not limited room searches per policy are conducted twice a day to ensur mitigation plans have taken pla safety of the unit and patients. occurred on 8-6-2018 through 8 2018, prior to working their first since the changes. Included in training process's and impleme  Intake- Wanding with a detector has commend every patient brought if facility. Belongings are inventoried and search	retrained entified to the re that rice for This 3-9- shift the ntations: metal ced for into the	
{A 144}	CFR(s): 482.13(c)(2) The patient has the right setting. This STANDARD is not litem #1 - Contraband Based on interview, received hospital policy and proceived to implement its policy.	nt to receive care in a safe met as evidenced by: ord review, and review of edures, the hospital staff olicies and procedures for	{A 144]	contraband.  O Admission-Wanding of with a metal detector a belongings inventoried/searched for contraband. All items of in with the patient are of inspected. A full body sof every patient admitted part of the screening for contraband. The patient undergoes skin check a inspection of contraban	ccurs ind  or any coming closely search ed is or int and	
	patient safety checks to entering the facility.	prevent contraband from		the body completed at t time. o On Unit- Utensils are ca monitored by staff. Staf	arefully	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES	PRINTED: 07/23/2018
CENTERS FOR MEDICARE & MEDICAID SERVICES	FORM APPROVED OMB NO. 0938-0391
	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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
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{A 144}	Continued From page	7	{A 144}			
	other hazardous items	prevent contraband and s from entering or being at risks patient, visitor, and		· .		
	Findings included:	•			·	
	procedure titled, "Uncl Search/Property Searc revised 06/18, showed are searched on admis indicated to ensure a s patients. Upon admissi possessions will be sea of sharps or contraban hospital either will secu patient's cubicle or will Upon admission to the an unclothed body seal execute a room search	ch," no policy number - I that personal possessions ssion and as clinically afe environment for all ion, all personal arched to prevent the entry d into the patient area. The ire restricted items in the send the items home. hospital, staff will conduct				
r p in s	erforms room searche ndicated for patient and	Searches," no policy showed that the hospital s twice a day and as I staff safety. Patients s, cigars, or pipes in their al listed bras as a				
in # p:	On 07/16/18 at 9:10 A terviewed a mental he 301) about room searc atients' personal items. oom searches are cond	alth technician (Staff hes and retrieval of Staff#301 stated that				

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	#301 was able to brin hospital without being that her understanding the items in her bra arremove her bra during safety search.  3. On 07/16/18 at 1:15 the medical record of record showed:  Patient #301 was adm 06/21/18 with major do hospital placed the parabservational checks are evaluated as high risk. The initial nursing assed data form dated 06/21, staff performed a body admission.  A psychiatric progress 1:40 PM showed that of the patient's room reverpatient stated she had first arrived to the hospital placed the hospital placed. THIS IS A REPEAT CRITED ON 06/07/18 tem #2 - Safe from Selegased on record review.	aff member how Patient g "vape pens" into the detected. Staff #301 stated g was that the patient hid not that the patient did not g the admission body and  5 PM, Surveyor #3 reviewed Patient #301. The medical  iitted to the hospital on expressive disorder. The tient on suicide every 5 minutes as she was for suicide.  essment and admission /18 showed that the nursing r and safety search upon  note dated 07/15/18 at on 07/14/18, a search of saled vape pens. The them in her bra when she oital.  FATION, PREVIOUSLY  If-Harm: 1 to 1 Monitoring v, and review of hospital	{A 144	A 144 Item #2 and #3 Plan of Corporation  Each specific deficiency Cited: The hospital failed to notify the princrease the level of observation who was making statements of superincrease the level of observation who was making statements of superincrease for implement of correction:  RN's, LPN's, and MHT's educated by nursing lead and Designee on 8-6-20 2018 or before working the since the changes in prohow to recognize and regine the patient's condition.  Mental Health Techs have retrained to immediately change in the patient's condition.  Registered Nurse, who wassess the patient and no provider and document the provider and document the correct precaution immediates and prior to working patient off precautions.  Staff were re-educated one of the changes were in conducting a suassessment upon aware of written journals entries or intentions of some conducting if a wincrease in precautions, and the jurse, and the jurse.	ovider or on a patient sicidal ideation. enting the plan were redership CNO 18 to 8-9-neir first shift cess, regarding ort a change or been report any ondition to the vill immediately offity the nat notification. Elent on the cliately, and remarks their first shift in being made, statements, of self harm, wider on call realable, of the autions by a stiffication for	
	olicy and procedure, t		1	the increase in p		[
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		(Patient #302) who had		behavior, increas		
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			1	depending on su	iciae risk	1

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:

DEPARTMENT OF HEALTH AND HUMAN SERVICES					PRINTE	D: 07/23/2018
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		one monitoring for being failure to protect patients a serious threat to the patients a serious threat to the patients and staff, whi injury and death.  Findings included:  1. Document review or procedure titled, "Obsidate 05/17, showed the one-to-one monitoring accompany the patient distance at all times. To patient performs personother self-care needs.  Document review of the procedure titled, "Precedure titled, "Precedure 05/17, showed that a level of precaution us represent an active suitother duties or responsione-to-one supervision.  2. On 07/16/18 at 3:00 If the medical record of Precord showed:  Patient #301 was admit 05/14/18 with major depositicide attempt.  On 06/29/18, Patient #36elf-Harm precautions with the serious procedure of the procedure of the medical strempt.	ents from self-harm and and staff members, poses health and safety of all ch could result in serious  If the hospital's policy and ervation Levels, "effective at patients placed on a require that staff it and stay within reaching his includes while the nal hygiene, toileting, and hospital's policy and aution: Suicide," effective at one-to-one monitoring is seed for patients who cide risk. Staff have no libilities other than the of the patient.  PM, Surveyor #3 reviewed attent #302. The medical ted to the hospital on pressive disorder with	{A 1	44}					

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o6/29/18 at 1:45 PM sincreased from Line of One-to-One monitoring breakfast and hiding it.  On 07/11/18, a physicial Patient #302 continue progress note stated, sharp utensil piece in it was a utensil piece) in one of the incident.  On 07/12/18, a nursing showed that Patient #302 continue piece of plastic. The new of the incident.  On 07/12/18, a physicial that Patient #302 continue plastic item. The note at was self-harming in the On 07/13/18, a physicial that Patient #302 continuonitoring. The note at have been episodes of Patient #302 with the physicial process of plastic staff put the patient into performed a room search	ogress note written on showed the patient's status of Sight Monitoring to gafter stealing a fork at it in his waistband.  It is an psychiatric note showed do to self-harm. The "Yesterday staff found a his mouth and today (there his laundry".  It day shift progress note 302 informed a mental he had swallowed a small curse notified the physician an psychiatric note showed mued on one-to-one do to swallowing a small also showed the patient a morning.  It is an an psychiatric note showed nued on one-to-one is o showed that there "sneaky behavior" by attent attempting to take a utensils last evening. It is a total ch.  In wrote an order that the finger foods.  AM, Surveyor #3 and Chief Nursing Officer	{A 144				

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	and one-to one monitor the ACNO how a patient monitoring could obtain self-harm. She stated performance issue and happened.  Item #3 - Suicide Asserbased on interview, recommended to implement the procedure for suicide a reassessment for 2 of (Patient #501 and Patient #501 and Patient #501 and Patient #501 and Patient providers, posed a seriand safety of all patient result in serious injury of the procedure titled, "Precedute 05/17, showed that for suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the procedure titled, "Precedute 05/17, showed that or suicide risk at least of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute of the precedute	ent on one-to-one in plastic utensils to this was a staff d should not have  essment  cord review, and review of redures, the hospital staff e facility's policy and assessment and 3 records reviewed ent #301).  Ints for suicide and failure ts' risk of self-harm to their rous threat to the health ts and staff that could or death.  the hospital's policy and aution: Suicide," effective t patients will be assessed upon admission and at vicide risk assessment thanges in behavior or reation. Staff will hysician/provider for any t of high or severe. A ent on Suicide or Line of	{A 1				
a W	pproval and notifies the ritten order.	attending physician for a  AM, Surveyor #5 and a					
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		ent #501 who was admitted						
	sulcidal ideation with a	M for the treatment of plan and intent, psychosis,						
	and bipolar depression of prior suicide attempt	n. The patient had a history						
		medical record review						
	07/13/18 prior to the p	tion Alert form signed on atient's arrival by the	_					
	nurse receiving hand-opatient #501 was a high							
	Data form showed that department on 07/13/1	essment and Admission the patient arrived to the 6 at 9:00 AM with the chief loughts and hallucinations.						
	high risk for suicide wit including a communica intent. The document s	nowed that the patient was h suicidal ideation, ted plan and had high howed that the patient was						
	admitted to the hospita with suicidal precaution	l for inpatient treatment is.						
	Record showed that the 15-minute observations 5-minute monitoring for	M, the Patient Behavior e patient was under every s, but did not receive every suicide precautions until ay (an elapsed time of 5						
; ;	#502 confirmed the find nursing staff receive no	dical record review, Staff ing and stated that tification of suicide risk via on form" on admission,				, and a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		

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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 06/2/18 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 "silt try wrister", "overdose on Xanax" and "drink bleach". Staff #303 also documented reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patient #301 threatened at the reading notes that showed Patie	PF	EFIX (EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULDBE		
The surveyor found no documentation in the	{A	and nurses can place precautions based of status without an initial 4. On 07/16/18 at 3: Officer (Staff #501) of placed on suicide profirst five hours of adrepatient should have monitoring upon admitted to the hosp depressive disorder.  The hospital placed to observational checks with an evaluation as The patient's condition 07/10/18, Patient #30 and Self-Harm Precason On 07/10/18, Patient #30 progress note stating Staff #302 read Patient notes alluding to killing patient that was on the Patient #301 listed five mention suicide. The replans for suicide includes "overdose on Xanax" a #303 also documented showed Patient #301 tencouraged the therap	the a patient on suicide on assessment or change in tial provider order.  OO PM, the Chief Nursing verified the patient was not ecaution monitoring for the mission and stated that the been placed on suicide mission at 9:00 AM.  5 PM, Surveyor #3 reviewed if Patient #301, who was ital on 06/21/18 with major The medical record showed:  The medical record showed:  The patient on suicide every 5 minutes consistent "high risk" for suicide.  In improved, and by 1 was on 15-minute checks utions.  PM, a mental health  I) wrote an inpatient that during a room check, at #301's journal and found go herself with another equit. In a separate note, a separate goals that notes outlined possible ding "slit my wrists", and "drink bleach". Staff if reading notes that hreatened a therapist and ist to commit suicide.	{A 144				

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		medical record to incinformed the register duty of her discovery.  The surveyor found redical record to incide duty (Staff #304) had assessment of Patier discovery nor had he provider on-call about technician's discovery.  On 07/11/18 at 12:22 order changing Patier precaution status to a restriction, and line of A physician psychiatro/1/11/18 at 2:00 PM scheduled the patient discovery of the journ physician confronted patient #301 stated, "matter what". The phy the designated crisis repatient for involuntary.  6. On 07/17/18 at 9:40 interviewed the Assist (ACNO) (Staff #302) abofficer (Staff #305) abofficer (Staff #305) abofficer (Staff #305) abofficer (Staff #305)	dicate Staff #301 had red nurse (Staff #304) on a conducted a suicide risk in the end of a conducted a suicide risk in the end of a contacted the physician or at the mental health by.  PM, a physician wrote an int #301's monitoring and suicide precautions, unit if sight precautions.  Ic progress note dated showed that the hospital had for discharge prior to the all entries. When the the patient the next day, I'm going to kill myself no visician made a referral for responder to evaluate the treatment.  DAM, Surveyor #3 ant Chief Nursing Officer	{A 1	44}	DEFICIENCY)			
	s ## h # P	she had spoken with the file of the file factor of the file factor of the file factor of the file factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the factor of the fa	the registered nurse ( Staff me of the incident. Staff the mental health technician but their discovery. Staff that when he was informed, ady asleep. In the morning, trmation about Patient #301						

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{A 144}			{A 14	A 405 Item #1 The Hospital failed to the CIWA protocol as ordered resulting medication error.	discontinue ( ng in a	8/9/2018
İ	#305 stated that she	ny shift nursing staff. Staff e changed the patient's			-	
	monitoring status up	on receiving the information		Procedure/process for implementing of correction:	ng the plan	
ļ	about the found mat	terial. Staff #305 and Staff			7400040	
	#320 could not find	any evidence in the medical		<ul> <li>Medical staff were trained or by the Medical Director to inc</li> </ul>	1 7/19/2018	
	record that staff info	rmed the on-call physician of		names of individual medicati	one to be	
	the journal notes the discovered.	e mental health technician		discontinued in the CIWA pro	otocol	
1	uiscovereg.			rather than writing "disconting	ue all	
(A 405)	ADMINISTRATION	OE DOLLCO		CIWA medications." Includin	g but not	
	CFR(s): 482.23(c)(1)		{A 40			
	O1 11(0): 402,20(0)(1)	), (C)(1)(1) & (C)(Z)		o Purpose, Frequency	y, Scoring,	
	(1) Drugs and biolog	icals must be prepared and		PRN medications,		
	administered in acco	ordance with Federal and	ļ	discontinuing medic protocol.	ations or	
	State laws, the order	s of the practitioner or		Nursing staff and pharmacy s	taff word	
- 11	practitioners respons	ible for the patient's care as		trained on 8-6-18 to 8-9-18 a	nd prior to	
1	specified under §482	2.12(c), and accepted		working their first shift since of	changes	
٤	standards of practice	<b>).</b>		initiated by the CNO or Asst.	CNO to	
	(i) Deues and blalasis			request clarification of any or	ders that	
	il) Diugs and Diologic	cals may be prepared and orders of other practitioners	1	contain "discontinue all CiWA	١	
	on included on the carriers	482.12(c) only If such		medications."		•
ء ا	ractitioners are actin	ig in accordance with State		}		
l la	aw, including scope	of practice laws, hospital		-		
p	olicies, and medical	staff bylaws, rules, and		Monitoring and Tracking procedures	s to	
re	egulations.	, , , , , , , , , , , , , , , , , , , ,		ensure the plan of correction is effective.  The CNO/ Designes will make	ctive:	
				The art of the continue will bloth	tor 100%	
(2	<ol><li>All drugs and biological</li></ol>	gicals must be		of all CIWA charts daily (5 day to ensure that all orders are w	/s a week)	
а	dministered by, or u	nder supervision of, nursing		correctly (or clarified) and proj	raten	
0	r other personnel in :	accordance with Federal		carried out.	July	
a	nd State laws and re	gulations, including		Staff who do not properly carry	vout the	
20	pplicable licensing re	equirements, and in approved medical staff		orders will receive coaching a	nd Í	į
po	olicies and procedure	es.		disciplinary action up to and in	cluding	
		ot met as evidenced by:		termination.	-	
	EM #1 - CIWA Proto			<ul> <li>Audit 5 days a week of all active</li> <li>CIWA/COWS charts.</li> </ul>	/e	
		· · · · · · · · · · · · · · · · · · ·				
				Process improvement: Address proc	ess	
VIS-2567(02-	-99) Previous Versions Obsol	efs Event ID: WOSU1	J 3 Fa	improvement and demonstrate how t	he Lation sheet Pag	

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.

8/9/2018

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	Based on interview, policies and proced ensure that nursing orders for medicatic patients (Patients # Failure to administe physician's orders a procedures places pmedication errors.  Findings included:  1. Record review of procedure titled, "Co Withdrawal Scale] & Withdrawal Assessmumber, effective daproviders will order unonitor the severity of guide potential prevention be administered accided by the providers will order unonitor the following:  2. Review of the medical howed the following:  3. A registered nurse 7/14/18 at 5:00 PM to the PRN [as needed]	trecord review, and review of ures, the hospital failed to staff followed physician 's on administration for 2 of 4 1101, and #1102).  I medications according to not hospital policies and satients at risk for harm due to the hospital's policy and power for the Climical Institute and of Alcohol]," no policy to 06/2018, showed that se of the Cliwa symptoms and intative therapy. For a expected to be in withdrawal ider may order medications according to the symptoms,  ical record of Patient #1101  received a verbal order on o implement the "Alcohol rding to the protocol, one of medications, ng, was to be administered	{A 4	05}				
Ai	atient #1101 had a C	sment Flowsheet" showed IWA score of 8 at 10:00 dministration record (MAR)		-				

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{A 405}	indicated that an RN [milligrams] of Chloro the physician's order receive the medication.  c. The MAR indicated another 50 mgs of Ch Review of the Alcoholshowed that there was score indicating that greater than 8.  d. On 07/16/18 at 2:0 interviewed the Chief #1101) about the result of the Chief Nursing Of documentation and the Know why nurses addicted the parameter 3. Review of the med showed the following	administered 50 mgs liazepoxide. According to the patient should only on for scores greater than 8. If that a nurse administered allordiazepoxide at 8:30 PM. If Assessment flowsheet as no corresponding CIWA the patient had a score  O PM, Surveyor #11 If Nursing Officer (Staff alts of the record review. Ifficer reviewed the nursing then stated that he did not ministered the medications are set in the CIWA protocol. Ical record of Patient #1102	{A 405}			
	07/09/18 at 3:50 PM. orders for both sched (Gabapentin, Thiamin the patient received eneeded) medications according to CIWA so b. On 07/11/18 at 11:4 order to discontinue the CIWA medications.  c. Review of the Medi Record (MAR) showe administer the schedu	e, Multivitamin and Folate) very day and PRN [as the patient received oring or patient symptoms. IO AM, a provider wrote an ne CIWA protocol and all				

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ti ti p tr lte	ne PRN orders. The dinat he was planning to roviders during the ne nerapeutics meeting.  em #2- Medication Errased on interview, rec	irector of pharmacy stated of discuss the issue with ext pharmacy and errors				-

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION IN INCOME.		LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504012	B. WING		Makada Mila Anada	]	R-C //17/2018	
	ROVIDER OR SUPPLIER POINT BEHAVIORAL H	OSPITAL		3955 18	FADDRESS, CITY, STATE, ZIP CODE 66TH ST NE SVILLE, WA 98271		71712016	
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	that nursing staff folio and procedure for rep administration errors (Patient #1103).  Failure to report medi hospital's ability to im administration process outcomes.  Findings included:  1. Patient #1103 was treatment of bipolar m #1103's medical record.  a. The "Allergies Wordnursing upon admission that an allest including Haldol (an amount of the patient had an allest including Haldol (an amount of the patient) at 10:55 AM mouth], Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs including Haldol 5 mgs included including Haldol 5 mgs including Haldol 5 mgs included including Haldol 5 mgs including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included including Haldol 5 mgs included includ	powed the hospital's policy porting of medication for 1 of 1 patients reviewed ication errors limits the prove medication ses and improve patient admitted on 6/26/18 for nania. Review of Patient rd showed the following:  Asheet" completed by on on 6/26/18 showed that argy to several medications nti-psychotic medication).  Allergies in the bottom left allergies included the da verbal order on for Ativan 1 mg PO [by PO, and Benadryl 50 mgs I "now".  All18 through 07/14/18, sistered the Haldol and the 1:00 AM.  And 07/14/18 at 2:55 AM, eived Haldol this AM	{A 4	05)				
ļ		d allergy. Provider notified.					-	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		504012	B. WING			R-C	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	]	STREET ADDRESS, CITY, STATE, ZIP COL		07/17/2018	
SMOKEY	POINT BEHAVIORAL H	DSPITAL		3955 156TH ST NE MARYSVILLE, WA 98271	<i>,</i>		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u>l</u>				
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	reaction till 8:00 AM."  2. On 07/16/18 at 3:00 interviewed the Chief #1101) about the result the Chief William of the Chief Nursing Officer of the day Surveyor #11 medical record, showed the error on 07/13/18 and nurse administered the checking the MAR for administration.  Neither the nurse who medication nor the nurmedication error complincident Report.  4. In the same patient's provider wrote an order corazepam 1 mg PO [bday as needed for sympton of the checking the Mark of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday as needed for sympton of the corazepam 1 mg PO [bday	D PM, Surveyor #11 Nursing Officer (Staff lits of the record review. icer reviewed the nursing infirmed the surveyor's  f a report completed by the (Staff #1101) on 07/16/18, reviewed the patient's ad that he was notified of at 8:00 PM and that the e medication without patient allergies prior to  administered the se who discovered the leted a Medication Error  is medical record, a r on 07/11/18 for y mouth! three times a	{A 40	DEFICIENCY)	APPROPRIATE	·	
ti ti A	imes per day rather tha he following days: 07/12/18 7:00 AM to 07 M, 2:40 PM, 6:55 PM a	n three times per day on 7/13/18 6:59 AM at 9:00 and 3:25 AM					
-0	07/14/18 7:00 AM to 07 M, 2:15 PM, 7:58 PM &	7/15/18 6:59 AM at 9:30					

MANE OF PROVIDER OR SUPPLIER  SMOKEY POINT BEHAVIORAL HOSPITAL  STREET ADDRESS, GITY, STATE, 2P CODE 3956 165TH ST NE MARYSVILLE, WA 98271  GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GRADIO GR			OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		ATE SURVEY
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PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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A 068	The Washington St (DOH) in accordance Participation set for this health and safe Onsite dates: 09/10. The survey was cordinated and surveyor #5. Surveyor #11. DOH staff found the corrected all Condit during the 07/16/18 survey follow-up vis. During the course of assessed issues relieved #80538 and #84468. DOH staff found the compliance with all (forth in 42 CFR, Acuthose standard-level CARE OF PATIENTS CARE CFR(s): 482.12(c)(4).	ate Department of Health ce with Medicare Conditions of th in 42 CFR 482, conducted ty complaint follow-up survey.  /18 to 09/12/18  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted by:  Inducted	A 06	1. A written PLAN OF CORRECT required for each deficiency lister Statement of Deficiencies.  2. EACH plan of correction statemust include the following: The regulation number and/or the number;  HOW the deficiency will be correction;  WHO is responsible for making the correction;  WHAT will be done to prevent reoccurrence and how you will me continued compliance; and  WHEN the correction will be come.  3. Your PLANS OF CORRECTION be returned within 10 days from the your receive the Statement of Definite required signatures.	d on the ement e tag cted; he onitor for pleted.  ON must he date iciencies.	
ORATORY	following requirement	R/SUPPLIER REPRESENTATIVE'S SIGNA	TUPE	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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		CO	TE SURVEY MPLETED
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	for the patient. Thes	e recommendations would be ding physician or treatment	A.u	,				
	team as appropriate	e.						ĺ
	2. During the survey	, Surveyor #5 reviewed the			,			
	at the hospital and in	ents currently being treated nterviewed hospital staff						1
	members. The reco	rd reviews and interviews			l  -			
	a. Patient #501:						ļ	
	for Patient #501. Thi on 05/31/18 for the tr Secondary Dissociati	taff #503), and the Program reviewed the medical record is patient had been admitted reatment of Schizophrenia, we Disorder, and Command as to harm self. The record						
	on 06/10/18 due to "p dietician's nutritional a patient had a 4 pound week. The dietician reprotein milkshake ond nutritional supplement	referred for a dietary consult poor intake." At that time, the passessment showed the second and a high ce daily; b) Ensure® (a tor meal replacement) after intake was less than 50%; direcord the patient's						
	08/28/2018 showed th	tion on 08/27/2018 and at the patient continued to ce and was refusing the			·.			
í	c) The dietician comple assessment on 08/28/	eted a nutritional 18. The assessment						

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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	sho sin offer less mill plan disconnection weight of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server patient of the server pa	owed that Patient ice admission. 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A Psychiatric Program of the patieng ght loss.  A Psychiatric Program of the	#501 had lost 10 pounds e dietician recommended nsure® if meal intake was providing a high protein daily. The dietician follow-up ht check and further patient about her intake in son evidence in the patient's showed the dietician preview or weight check and's poor dietary intake and ress Note completed on stated, "Sleep and appetite bilization and follow up with inue current milkshakes und no evidence the addreviewed the dietician's ation to increase the day.  The Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Progress of the Daily Nursing Pro	A 0	38			

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t s v F d d lo 3 w # th	continued to show the protein milkshakes we twice per day as record 2) On 09/10/18 at 12 with Surveyor #5, the that a provider did not and that the dietician The dietician was unautritional assessment as tated the dieticiar recommendations for Patient #501 should be shakes twice daily. So know if the patient was supplements and she documented how much patient consumed she had not followed a veighed the patient polan. She verified the place of the patient did not know being weight.  On 09/10/18 at 12:1 with Surveyor #5, the F508) verified the installant 50% and confirmed as 150% and confirmed the protein the patient polant.	dated 08/30/18 to 09/10/18 hat the patient order for vas once per day rather than ommended by the dietician.  3:00 PM, during an interview e Dietician (Staff #506) stated of need to write a diet order consultation was enough. aware of the revised hat and screening procedure an only made of diet orders. She stated that the receiving the high protein he stated that she did not sereceiving the Ensure® of the dietary supplement. The dietician confirmed hap with the patient nor fer the nutrition consultation for were no other weights me of the interview, the if the patient was gaining or 5 PM, during an interview Program Director (Staff lances of meal intake less and there was no	AC	068	DEFICIENCY)	TROPRIATE .	TALE
to	ocumentation of the E erified there were no o e "neurological/vital s neet. She stated there ocumented because to take the patient's we 5/31/18). She stated to ade a recommendation	Ensure® supplements. She documented weights on igns check/weights" flow					

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AND PLAN OF CORRECTION (AT) PROVIDENT		IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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i	must write an order provider did not write not have received the 08/29/18 and the countitien by the provided 4) On 09/10/18 at 11 Nurse (Staff #507), drinks and the Ensure documented either of progress note. Survestaff offered or documented or documented either of supplements. Surves about the missing de #501's medical record for every was no standard documenting administration supplements.  b. Patient #503:  1) On 09/11/18 at 11 Registered Nurse (Registered Nurse (Registered Nurse (Registered note) and review showed the form of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the proposed of the pro	She stated because the se an order, the patient should he high protein shake twice on orrect order was the order state of the high protein stated that the high protein stated that the high protein stated that the high protein stated that the high protein stated that the high protein stated that the high protein stated that on a nursing eyor #5 found no evidence mented the Ensure® yor #5 questioned Staff #507 becomentation in Patient rd. Staff #507 stated that ordized process for stration of dietary  140 AM, Surveyor #5 and a N) (Staff #510) reviewed the satient #503. This patient had /07/18 for the treatment of suicide attempt. The record ollowing:  15 for a complete blood count is showed that the patient's 100 mg/dL (high). The lab 39 mg/dL as normal.	A	068						
ļ p	ەrovider (Staff #511) ب	wrote an order for a dietary cation related to elevated			·					
c	) On 09/10/18 at 11:	19 AM, the dietician (Staff		1				ĺ		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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SMOKE	Y POINT BEHAVIORAL	_ HOSPITAL		3	3955 156TH ST NE MARYSVILLE, WA 98271		
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	#506) completed a documented the cor Assessment Form." a fasting triglyceride level and to start a head to start a head reviewed the recipied dietician. The RN start provider had reviewed verified there was not to confirm the provide consult.  c. Patient #504:  1) On 09/12/18 at 9:2 Senior Clinical Vice-F (Staff #501), and a R #512) reviewed the mr #504 who was admitt treatment psychosis, ideation. The record real On 08/12/18 at 5:5 healthcare provider on the papetite and had lost a month. The healthcare or a dietary consult for a dietary consult for eight loss of plus or minus one month.	dietary consultation and insult on a "Nutrition". The dietician recommended lab test to assure the correct leart healthy meal plan.  On PM, Surveyor #5 asked a N (Staff #510) if the provider commendations from the lated she did not know if the lead the consultation and of documentation in the chart er had reviewed the dietary.  All AM, Surveyor #5, the President of Compliance legistered Nurse (RN) (Staff ledical record for Patient led on 08/12/18 for the depression and suicidal review showed the following:  O PM, the admitting redered a dietary consult.  All aluation completed on showed that the patient's latent had decreased legion over the past legion provider wrote an order or gluten-free diet due to a minus 20 pounds in plus or letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the consultation on letted the letter lead the consultation on letter letter lead the consultation on letter lead the consultation on letter lead the consultation on letter lead the consultation on letter lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead the consultation lead t	A	068			
	8/14/18 at 2:20 PM. 7	The dietician noted in the					

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SMOKE	Y POINT BEHAVIORAL	HOSPITAL		3	3955 156TH ST NE		
				Į.	MARYSVILLE, WA 98271		
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	minus 20 pounds in lab values that show 5.9 (Normal range 6 (g/dL). The dietician supplements to optinitake, and recommendikshakes two time PM.  e) On 09/04/18 at 10 provider wrote an ordered shakes. Surveyor #5 provider had ordered The Registered Nurs that the patient was reshakes. f) Documentation shotaken on admission to taken on admission to Staff #501) if the prodiction consultation Staff stated that she deview of the docume was no way for staff to eviewed the dietary of the confirmed there we have the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed the confirmed there we was no way for staff to eviewed the dietary of the confirmed there we was no way for staff to eviewed the dietary of the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confirmed the confi	e patient has lost plus or the past month and reported yed a low total protein level of .0 to 8.3 grams per deciliter recommended nutritional mize caloric and protein ended high-protein nutritional s daily at 10:00 AM and 2:00 at 10:00 AM, a healthcare der to discontinue the protein found no evidence a the high protein shakes. The (RN) (Staff #512) stated not receiving high protein and receiving high protein and receiving high protein conditions. The lide of the hospital.  O AM, Surveyor #5 asked be-President of Compliance vider had reviewed the and recommendations. It do not know, and after intation, confirmed there is identify if the provider consultation. At this time, was no provider order for and staff had not weighed	AC	068			
3 re	On 09/12/18 at 10:0	00 AM, Surveyor #5 record a second time with a			•	ļ	

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

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	O. 0938-03 ATE SURVEY OMPLETED	<u>191</u>
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NAME OF	PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 08	9/12/2018	
	Y POINT BEHAVIORAL				955 156TH ST NE #ARYSVILLE, WA 98271			
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{A 144} [	from 0% to 100%, b Staff #502 stated that had decreased intak psychological status (Staff #506) stated the patient received the and she did not know high protein shakes. #502 how she comm nutritional status or r attended the patients Staff #502 stated she team meetings, but t ask providers to write	ut averaged around 50%.  at it appeared that the patient be around times of worsening.  At this time, the dietician that she did not know if the high protein shakes or not, or if the provider ordered the Surveyor #5 asked Staff funicated a patient's funicated a patient's funitation concerns and if she orders when the treatment that sometimes she would be orders when she saw them.  EARE IN SAFE SETTING	A 0					
I f t f ii p iir tf	setting. This STANDARD is r Based on interview, r hospital policies and r failed to ensure hospi the policy and procedi for 1 of 2 occurrences hospital staff member incident report when co patient's room, and ho hovestigate how the co he hospital  failure to report, invest ontraband and other	hazardous items from hospital risks patient.						

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/12/20	)18
SMOKE	Y POINT BEHAVIORAL	. HOSPITAL		3955 156TH ST NE MARYSVILLE, WA 98271		
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	procedure titled, "Ro number, revised dat staff members would contraband at least to included prohibited it and paraphernalia. To staff discovered confiscate the items; patient, the patient's Chief Nursing Officer report.  2. On 09/11/18, Survey medical record for dischad been admitted on of psychosis and schareview showed that on healthcare provider on On 08/07/18 at 5:00 Ashowed a positive resipancy in paily Nursing Progresshowed that on at 1:0	scharged Patient #502 who n 08/04/18 for the treatment izophrenia. The record n 08/06/18 at 4:21 PM a redered a urine drug screen ault for methamphetamine. A ss Note" dated 08/07/18 0 PM staff discovered a k fluid in the patient's room				
ti fo ir S	ne hospitals incident i ound no evidence tha ncident report followin	evidence that the hospital				
S   D   #!	urveyor #10 discusse irector of Process Im 505). Staff #505 state	AM, Surveyor #5 and the finding with the provement and Risk (Staff d there were no incident aband in August 2018. He				

DEPARTMENT OF HEALTH AND HUN

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STATEMENT OF DEFICIENCIES (X1) PR IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
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66 irr (V) ta oo tin D no	5. On 09/11/18 at 11 Surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5, a Regiment and surveyor #5 and Surveyor #5 and Surveyor surveyor #5 and Surveyor surveyor #5 and Surveyor surveyor #5 and Surveyor surveyor #5 and Surveyor surveyor #5 and Surveyor surveyor surveyor surveyor surveyor #5 and Surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor surveyor	re" of the incident, but could not report.  :05 AM during interview with stered Nurse (RN) (Staff estaff conducted contraband once on day shift and once on stated that a Licensed N) (Staff #507) and a Mental MHT) (Staff #513) told him methamphetamine after they tress in the patient's room on the LPN and the MHT ge. He stated that he went to 22 and reported the incident bered going to her office, as sky because (he) had never re and (he) needed that Staff #502 told him to at in the chart. He stated he are completed an incident asked the patient how she mine the patient stated that lik about it.  29 AM, Surveyor #5 cal's Chief Nursing Officer taff #502 stated that she dent, but could not recall in her office or recall the not. She stated that at the ne was working as the revention and Education, NO.  PM, Staff #505 presented by or #10 with an incident day by the MHT (Staff	{A 1	14}				
#5	port completed that of 13) who found the sy	day by the MHT (Staff yringe						

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{A 144}	Continued From pag	ge 11	{A 14	14}	·		
	report process. Staff conducted contrabar on day shift and once told the Surveyor that contraband he report nurse and the Chief I asked Staff #513 if he	13 regarding contraband, y searches, and the incident #513 stated that staff and checks twice daily, once to on night shift. Staff #513 to when he found the fied the incident to the charge Nursing Officer. Surveyor #5 to filled out an incident report dent and he stated he did					

Event ID: WOSU14

Facility ID: 013134

If continuation sheet Page 12 of 12

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ORM CMS-2567(02-99) Previous Versions Obsolete