STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 08/22/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE COMPLAINT INVESTIGTION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint. Onsite date: 08/22/2018 Intake number: 83582 The investigation was conducted by: Surveyor #27347 During this complaint investigation staff determined that the facility was NOT IN COMPLIANCE with the Medicare Conditions of Participation set forth in 42 CFR Part 482: 42 CFR 482.12 Governing Body	A 000		
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this	A 068		9/5/18

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

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

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A 068	Continued From page 1	A 068		

section, with respect to chiropractors.

This STANDARD is not met as evidenced by:
Based on interview, review of hospital documents and review of acute care hospital documents the hospital failed to include the medical doctor in the care of a patient (Patient #1)

Failure to include the medical director in the day to day care and assessments of patients with complex medical needs risks deterioration of the patient's condition and poor outcomes.

Findings include:

1. The hospital policy titled "Medical Service Encounter" revised 05/5017 read in part "To provide for a patient's medical needs in a timely manner. The registered nurse: Requests medical services for patient illness, trauma, chronic medical conditions".

2. Review of Patient #1's record revealed she was admitted to the hospital on 03/22/2018 due to "psychosis-hearing voices telling her not to eat". Throughout her stay she did not consistently consume food or fluids or her medications often refusing to take her medications or eat and drink. Medications were ordered by injection IM (intramuscular) and the patient consented to receive their medications by IM injection.

On 04/03/2018, and 04/24/2018 and 05/28/2018 the hospital sent the patient to the local acute care hospital emergency room (ER) for evaluation of abnormal labs. Each time the ER evaluated the patient and repeated the lab tests that were resulted as normal in the ER.

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A 068	Continued From page 2	A 068		

On 6/16/2018 the patient was sent to the local acute care hospital ER after falling in the hospital. The ER did a work-up of the patient's fall with x-rays of the patient's pelvis, hips, ribs and arms and found the patient to have fractured humerus (arm) but no other fractures were identified. The patient was not a candidate for surgery and was sent back with their arm in a sling for the fracture.

On 06/19/2018 the hospital sent the patient to the acute care ER due to refusing medications and oral fluids. The ER staff talked with the behavioral hospital nurse sent with the patient to the ER. The nurse felt comfortatble taking the patient back to the hospital.

On 06/23/2018 hospital psychiatric consultation notes stated "Asked to evaluate would patient benefit for nursing home care". "Patient elderly female who isn't getting out of bed to urinate". "fecal incontinence". "Poor po (oral) intake". "If change in level of consciouness may send to ER (emergency room) for evaluation".

On 06/29/2018 hospital psychiatric consultation notes stated "Patient lying in bed and no response to questions and appears to be confused. Has not been eating or drinking for at least 4 days, refuses medications. Her physical conditions are deteriorating. Emergency meeting held with medical director, chief operating officer and patient's daughter. All agreed to send patient to emergency room and patient needs to be admitted to medical floor for treatment".

On 06/29/2018 the acute care hospital admitted the patient to the medical floor. The patient was found to be "hypotensive with systolic blood

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pressure in the 80's, hypoglycemia, a humerus fracture, and schizoaffective disorder. After receving IV fluids the patient was able to answer questions asked by the hospital staff and relayed falling in the facility last week and "broke their arm".

3. There was no documentation found to indicate the medical doctor was involved in reassessing the patient's medical condition during their hospital stay, after emergency room visits or in talking with the emergency room staff about the patient's condition.

4. On 08/22/2018 at 11:00 AM Staff A was interviewed. Staff A stated that patients needed to be able to eat and drink by themself and if they were not able to do this they would need to be transferred to another care setting possibly a nursing home or acute care hospital. Staff A stated the psychiatrist was the primary person to notified of patient changes.

5. On 08/22/2018 at 11:30 AM Staff B verified the above information.

6. On 8/22/2018 at 12:00 PM Staff C stated the behavioral health hospital was looking at their admission criteria to ensure they did not take patients that were not able to adequately perform their own ADL's were not admitted to the facility. Staff C stated the psychiatrist would call the medical doctor if a consult or reassessment was needed.