FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED A. BUILDING: __ 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X\$) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 000 INITIAL COMMENTS L 000 STATE LICENSING SURVEY 1. A written PLAN OF CORRECTION is The Washington State Department of Health required for each deficiency listed on the (DOH) in accordance with Washington Statement of Deficiencies. Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital 2. EACH plan of correction statement Licensing Regulations, conducted this health and must include the following: safely survey. The regulation number and/or the tag Onsite dates: 04/03/23 to 04/05/23. number: Examination number: X2023-280 HOW the deficiency will be corrected; The survey was conducted by: WHO is responsible for making the Surveyor #7 correction: Surveyor #8 Surveyor #10 (who was in orientation) WHAT will be done to prevent reoccurrence and how you will monitor for The Washington Fire Protection Bureau continued compliance; and conducted the fire life safety inspection. (See shell # 0Y0C21) WHEN the correction will be completed. During the course of the survey, surveyors also 3. Your PLANS OF CORRECTION must investigated the following complaint(s): # be returned within 10 calendar days from 2022-5625 and #2023-3414. the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by April 24th, 2023. 4. Return the REPORT electronically with the required signatures. L 315 322-035.1C POLICIES-TREATMENT L 315 WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

written policies and procedures consistent with this chapter and

TITLE

(X6) DATE

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WNG 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 315 Continued From page 1 L 315 services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: Based on interview, medical record review, and review of the hospital's policy and procedure, the hospital failed to ensure staff followed the policy on close observation and documentation for 10 of 14 Observation Records reviewed (Patient's #702, #703, #704, #705, #706, #707, #708, #709. #710 and #711). Failure to document Physician Ordered Precautions and the patients' observation level can lead to patient elopement or serious risk to patient safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Sheet Documentation Guideline" Policy # PC028, last reviewed 07/22 showed the following: a. The following should be documented every (q) 5 or q15 minutes as ordered: i. The patient's exact location. ii. Pertinent descriptions of the patient's current condition, behavior, or activity. iii. Significant patient responses to the care provided by staff.

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discontinued.

iv. Time that precautions were implemented and

State of	Washington				FOR	M APPROVED
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			A. BUILDING:			
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L315	Continued From page	e 2	L 315			
	Nurse Manager (Staf	he patients in the Women's				
	a. Patient #702 was of and was missing 3 q5	on q5-minute precautions 5-minute rounds.				
	b. Patient #703 was o was missing 2 q15 m	on q15-minute rounding and ninutes checks.				
	c. Patient #704 was of was missing 4 q15-mi	on q15-minute rounding and ninute checks.				
	d. Patient #705 was o was missing 4 q15-mi	on q15-minute rounding and ninute checks,				
	e. Patient #706 was o was missing 10 q15-n	on q15-minute rounding and minute checks.	T T T T T T T T T T T T T T T T T T T			4
	f. Patient #707 was or was missing 16 q15-n	n q15-minute rounding and minute checks.				T T T T T T T T T T T T T T T T T T T
	g. Patient #708 was o was missing 16 q15-n	on q15-minute rounding and minute checks.				
	h. Patient #709 was o was missing 4 q15-mi	on q15-minute rounding and inute checks.				
`	i. Patient #710 was or was missing 4 q15-mi	n q15-minute rounding and inute checks.				
	j. Patient #711 was on was missing 6 q15-mi	n q15-minute rounding and inute checks.			j	
		eview Staff #701 verified 10 eets were missing 2 or more ion.				
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State Form 2567

State of Washington

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L1065	Continued From page	3	L1065			
L1065	322-170.2E TREATM	ENT PLAN-COMPREHENS	L1065			
	WAC 246-322-170 F Services. (2) The licer provide medical super treatment, transfer, and planning for each patinetained, including builmited to: (e) A compit treatment plan develous eventy-two hours foll (i) Developed by a mutreatment team with in appropriate, by the parand other agencies; (modified by a mental professional as indical patient's clinical conditinterpreted to staff, paymen possible and apfamily; and (iv) Implemensons designated in This Washington Admas evidenced by: Item #1 Date and times	nsee shall rvision and nd discharge ient admitted or t not rehensive sped within lowing admission: ulti-disciplinary nput, when stient, family, (ii) Reviewed and health sted by the stition; (iii) attent, and, spropriate, to mented by n the plan; sinistrative Code is not met				
	Based on record revie hospital failed to ensu	re that staff members				
	completed the Comprisinclude the date and to	ehensive Treatment Plan to				
		one for 5 or 7 records 01, #712, #713, #714, and				
	#715).	with the section of t				
State Form 256	behavioral and medici patients at risk for inal delayed care, creating	ciplinary treatment plan for				

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING: _ 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION! TAG TAG DEFICIENCY) L1065 L1065 Continued From page 4 patient outcomes, harm, or death. Findings included: 1. Document review of the policy titled, "Treatment planning" Policy# MS.16, last reviewed 01/22, showed the following: a. Within 72 hours of admission, the first Treatment Team meeting will be held and the Master Treatment Plan will be prepared by the multidisciplinary team and signed by the attending physician. 2. On 04/03/23 at 10:06 AM, Surveyor #7, The Nurse Manager (Staff #701), reviewed the medical record of Patient #701. Patient #701 was admitted on 03/30/23 at 6:40 PM. Patient #701 had a Master Treatment Plan (MTP) dated 04/03/23 that did not include the time of the provider/staff signature. 3. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 4. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #712 who was admitted on 03/31/23 at 12:25 AM, The review showed the patient had a MTP that showed no Psychiatric provider participation. 5. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 6. On 04/04/23 at 11:00 AM, Surveyor #7 and Staff #701 reviewed the medical record for

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 8. WING 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 605 WOODLAND SQUARE LOOP SE **SOUTH SOUND BEHAVIORAL HOSPITAL** LACEY, WA 98503 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY L1065 Continued From page 5 L1065 Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the multidisciplinary MTP meeting had no time documented on the form. 7. At the time of the review Staff #701 verified there was no place on the form for staff or patients to document a time on the time-sensitive document. 8. On 04/04/23 at 11:31 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 03/15/23 at 1:45 AM. The review showed no time noted on the MTP. 9. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 10. On 04/04/23 at 1:00 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 01/27/23 at 1:40 AM. The review showed no time noted on the MTP 11. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 12. On 04/04/23 at 3:18 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #715 who was admitted on 02/08/23 at 12:50 AM. The review showed no time noted on the MTP. 13. At the time of the review Staff #701 verified there was no time documented and no place on

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State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: _ 04/05/2023 013319 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1065 L1065 Continued From page 6 the form for staff or patients to document a time on the time-sensitive document. Item #2 Incomplete MTP Based on document review and interview the hospital failed to ensure a multi-disciplinary treatment team completed the Master Treatment Plan (MTP) for 4 of 7 records reviewed, (Patients #701, #712, #713, and #716). Failure to ensure the development of a complete Comprehensive Treatment Plan for behavioral and medical problems places patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the policy titled. "Treatment planning" Policy# MS.16, last reviewed 01/22, showed the following: a. Within 72 hours of admission, the first Treatment Team meeting will be held and the Master Treatment Plan will be prepared by the multidisciplinary team and signed by the attending physician. i. Specific departmental strategies are written by the individual discipline members. ii. Patient goals and staff strategies will be based upon assessments conducted and records received within the first week of hospitalization, b. Goals are established in reference to specified problems. i. Goals are achievable with target dates and State Form 2567

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX PREFIX TAG L1065 L1065 Continued From page 7 written in measurable terms, b. Specific strategies or treatment modalities will be identified and the responsible staff/discipline will be indicated. c. The treatment plan, goals, and progress toward these goals will be reviewed and revised by the Treatment Team weekly or more often as clinically indicated. 2. On 04/03/23 at 10:06 AM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the medical record for Patient #701 who was admitted on 03/30/23 at 6:40 PM. Review of the medical record showed the following: a. Patient #701 had a MTP dated 04/03/23 with the following problems listed; Psychiatric problems i. High Risk for Suicide. ii. Danger to self with Psychosis. Medical problems iii. Substance-related detox. iv. Risk of complication during detox. v. Risk for injury related to Seizure. vii. Risk of falls. viii. Impaired skin integrity, ix. Hypertension (HTN). x. Chronic pain.

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L1065	Continued From page	e 8	L1065			
	xi. Insomnia.					
	xii. Asthma.					
	xiii. Gerd.					
	xiv. Impaired physica					
		ization: cast, limb, joint by splint on Left leg for				
	xvi. HTN.					
	b. The Treatment Tea Program Therapist.	m was only signed by the				
	(Staff #702) who state working on the MTP a opportunity to comple	and had not had an ite it due to the weekend.				
		rised they had not yet held Naster Treatment meeting.				
	4. At the time of the re incomplete MTP and completed within 72 h admission.					
	#701 reviewed the me #712 who was admitte The review showed the	9 AM, Surveyor #7 and Staff edical record for Patient ed on 03/31/23 at 12:25 AM. ne patient had a MTP that c provider participation.				
	6. At the time of the reincomplete MTP and completed within 72 hadmission.					

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FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER;** COMPLETED A. BUILDING: _ B, WNG 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY)** L1065 Continued From page 9 L1065 7. On 04/04/23 at 11:00 AM, Surveyor #7 and Staff 3701 reviewed the medical record for Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the following: a. The multidisciplinary MTP meeting was not completed within 72 hours. No Psychiatrist was represented at the initial MTP meeting. b. The MTP update held on 01/30/23 had no Physician in attendance. 8. At the time of the review Staff #701 verified the incomplete MTP and that it had not been completed within 72 hours of the patient's admission 9. On 04/04/23 at 3:18 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #716 who was admitted on 02/08/23 at 12:50 AM. The review showed the MTP was signed by the Psychiatrist the PT, RT, and the Patient on 02/09/23. The RN signed on 02/14/23, 6 days after the patient arrived. 10. At the time of the review Staff #701 verified the MTP had not been completed within 72 hours of the patient's arrival. L1100 322-170.3B PSYCHIATRIC SERVICES L1100 WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff,

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including: (b) Psychiatric services,

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ 04/05/2023 013319 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L1100 Continued From page 10 L1100 including: (i) A staff psychiatrist available for consultation daily and visits as necessary to meet the needs of each patient; and (ii) A child psychiatrist for regular consultation when hospital policy permits the admission of children or adolescents; This Washington Administrative Code is not met as evidenced by: Based on interview, and document review the hospital failed to ensure that a child psychiatrist is available for regular consultation when hospital policy permits the admission of children or adolescents. Failure to have a child psychiatrist available for consultation when the hospital has children or adolescent patients puts these patients at risk of receiving incomplete treatment. Reference: WAC 246 322 010 Definitions: (7) "Child psychiatrist" means an individual licensed as a physician under chapter 18.71 or 18.57 RCW who is board-certified or board-eligible with a specialty in child psychiatry by: (a) The American Board of Psychiatry and Neurology; or (b) The Bureau for Osteopathic Specialists. American Osteopathic Neurology and Psychiatry. Findings included: 1. On 04/03/23 at 8:30 AM, Surveyor #8, Surveyor #10, and Surveyor #7 interviewed the CEO (Staff #803) about the provision of adolescent services at the hospital. Staff #803 stated that the 2nd floor the hospital has an adolescent unit.

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ 8. WNG 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 SHMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1100 Continued From page 11 L1100 2. On 04/05/23 at 10:15 AM, the Medical Director (Staff #802) was interviewed by Surveyor #8, Surveyor #10, and Surveyor #7. During the interview, Staff #802 stated that to be a child psychiatrist requires specialized and additional medical training. He stated that he is not aware of anyone with child psychiatry training currently privileged to provide consultation at South Sound Behavioral Hospital. L1295 L1295 322-200.3L RECORDS-PROGRESS NOTES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (I) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities; This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital failed to ensure prompt entry of initial recreational therapy assessments in the medical record for 3 of 6 patients reviewed (Patient #1004, #1005, and #1006). Failure to document initial assessments risks patient harm from unrecognized or unmet care

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needs, and inconsistent and unsafe care due to

an incomplete medical record.

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L1295	Continued From page	3 12	L1295			
	Findings included:					
		of the hospital's policy titled, essment of Patients," no yed 01/22, showed:				
	a. All patients admitte Behavioral Hospital w assessment and eval	ill receive a thorough				
	multidisciplinary treate	ewed and integrated by the ment team to prioritize thin the interdisciplinary				
	is completed within 72 includes (in part) infor					
	restrictions and preca	d orders received; physical utions; attitude and affect; lem solving skills; social and coping skills:				
333	concentration; insight; Summary contents inc	and leisure skills.				
		ecipitating event, and an nt plan are also included.				
	Chief Nursing Officer	DPM, Surveyor #10 and the (Staff #1001) reviewed the atients #1004, #1005, and owed the following:				
	4:40 PM. Surveyor #1	admitted on 03/04/23 at 0 found no evidence that an sment had been completed				
	8:00 PM. Surveyor #1	admitted on 03/03/23 at 0 found no evidence that an sment had been completed				

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	8:00 PM. Surveyor #1 activity therapy asses within 72 hours. 5. At the time of the reverified there was no activity therapy asses records of Patient #10 6. At the time of the reinterviewed the Direct #1002) about the resp	admitted on 02/09/23 at 0 found no evidence that an sment had been completed accord reviews, Staff #1001 documentation of initial sments in the medical 104, #1005, and #1006. Accord reviews, Surveyor #10 or of Clinical Services (Staff tonsibilities of recreational 2 confirmed that the is to complete an initial feach patient within 72				
L1390	WAC 246-322-210 Ph Medication Services. shall: (3) Develop and procedures for prescri and administering med according to state and and rules, including: (f Authenticating verbal a orders by prescriber in manner, not to exceed hours for inpatients; This Washington Admi as evidenced by: Based on interview an	The licensee implement bing, storing, dications I federal laws) end telephone I a timely I forty-eight inistrative Code is not met d document review, the	L1390			
tale Form 256	hospital failed to ensu	re prompt filing into the				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
L1390	Continued From page	14	L1390		
	patients (Patients #70 #1001, #1002, and #1	verbal orders for 7 of 16 91, #713, #714, #715, 9003).	Tomorous 4.		
	Failure to authenticate patients at risk of harm medical error.	e orders promptly puts n from improper care and			,
	Findings included:				
	"Medication Ordering				
		ne hospital policy titled, plicy number RC 001, last d the following:			
	a. Purpose: to provide orders.	guidelines for processing			
	b. All physician orders electronic medical rec	shall be written [in the] ord system.			
THE PROPERTY OF THE PROPERTY O	electronic medical rec	s entered directly into the ord system by a nurse must rdering physician within 48			
	Nurse Manager (Staff				
		or a dietary consult and a drawal Assessment (CIWA)			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE O			SURVEY PLETED
		013319	B. WING		04	/05/2023
NAME OF P	ROMDER OR SUPPLIER	STREET A	DDRESS. CITY, STATE	E, ZIP CODE		
SOUTH S	OUND BEHAVIORAL HO	SPITAL	DDLAND SQUARE WA 98503	LOOP SE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L1390	Scale order was place by a Registered Nurs authenticated by the AM, 83 hours and 34 placed. b. A telephone order 90mcg inhalation, wa PM by an RN (Staff # the provider on 04/03 and 47 minutes after 3. At the time of the medication order was hours after being place consult and CIWA scauthenticated within 4. On 04/03/23 at 2:3 Chief Nursing Officer electronic medical recreive showed: a. An order entered be on 01/19/22 was not 02/17/22 (29 days). b. An order entered be 02/20/22 was not co-03/25/22 (34 days). c. An order entered be 03/04/23 was not co-03/10/23 (6 days). 5. At the time of the rethat the orders had not the hospital policy time.	ed on 03/30/23 at 10:40 PM e (RN) (Staff #702) and provider on 04/03/23 at 9:54 minutes after the order was for the medication, Albuterol s placed on 03/31/23 at 1:07 (703) and authenticated by /23 at 9:54 AM, 68 hours the order was placed. eview Staff #701 verified the enot authenticated within 24 (22 dby an RN and the dietary ale orders were not 18 hours. 10 PM, Surveyor #10 and the (Staff #1001) reviewed the cord for Patient #1001. The cord for Patient #1001. The y an RN for amlodipine 5mg co-signed by a provider until y an RN for transfer on signed by a provider until eview, Staff #1001 verified of been authenticated within eframe.	L1390			
State Form 25		00 AM, Surveyor #7 and		***	· ·	

STATE FORM

State of	Washington				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		John Ected
		013319	B. WNG		04/05/2023
			ADDEDO CITY PTA	TE 20 CODE	1 04/00/2020
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA ODLAND SQUAR		
SOUTHS	OUND BEHAVIORAL HO	SPITAI	NA 98503		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L1390	Continued From page	16	L1390		
		e medical record for Patient ed on 01/24/23 at 9:56 PM. ne following:			
		for Culturelle was placed on by an RN (Staff #704).			
		for Calcium Carbonate 500 /28/23 at 4:47 PM by an RN			
	7. At the time of the re Culturelle and Calciur authenticated by a pro	n Carbonate had not been			
		eview, Staff #701 verified was not authenticated within blaced by an RN.			
	Staff #701 reviewed th	admitted on 03/15/23 at			
		for transdermal nicotine 23 at 10:51 AM, by an RN			
		for Queliapine oral 100 mg 23 at 10:53 AM, by Staff			
		for Quetiapine oral 300 mg 23 at 10:54 AM, by Staff			
	10. At the time of the orders had not been a	review the 3 medication authenticated.			
	11. At the time of the r	eview, Staff #701 verified			

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL LACEY, WA 98503 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1390 Continued From page 17 L1390 the medication order was not authenticated within 24 hours after being placed by an RN. 12. On 04/04/23 at 11:45 AM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1002. The review showed: a. An order entered by an RN for transfer on 03/22/23 had not been co-signed by a provider at the time of the review (13 days). b. An order entered by an RN for discharge to higher level of care on 03/22/23 had not been co-signed by a provider at the time of the review (13 days). 13. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe. 14. On 04/04/23 at 1:30 PM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1003. The review showed an order entered by an RN for wound care consult on 02/11/23 was not co-signed by a provider until 02/15/23 (4 days). 15. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe. 16. On 04/04/23 at 1:41 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #715 who was admitted on 01/27/23 at 1:40 AM. The review showed the following:

State Form 2567

a. A medication order for Albuterol inhalation was placed on 01/27/23 at 3:20 AM, by an RN (Staff #706). The order was authenticated on 03/03/23 at 2:06 PM, 6 days after being placed by the RN.

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: _ B. WING 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1390 Continued From page 18 L1390 17. At the time of the review Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN. L1525 322-230.2H FOOD SERVICE-MENU PLANNING L1525 WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible managing and supervising dietary/food services twenty-four hours per day, including: (h) Ensuring all menus: (i) Are written at least one week in advance; (ii) Indicate the date, day of week, month and year; (iii) Include all foods and snacks served that contribute to nutritional requirements; (iv) Provide a variety of foods; (v) Are approved in writing by the dietitian; (vi) Are posted in a location easily accessible to all patients; and (vii) Are retained for one year; This Washington Administrative Code is not met as evidenced by: Based on observation, interview and document review, the hospital failed to ensure that patient menus were posted in a location easily accessible to all patients.

State Form 2567

nutrition.

Failure to provide a menu that is easily accessible restricts the patient's ability to select their dietary options. This inability to select dietary options puts patients at risk of harm from inadequate

State of Washington (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: __ B. WING 013319 04/05/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X\$) COMPLETE Ю PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) L1525 L1525 Continued From page 19 Findings included: 1. On 04/03/23 between 10:00 AM and 11:00 AM. Surveyor #8 toured units on the 2nd and 3rd floors with Infection Preventionist (Staff #801). Staff #801 was interviewed regarding where food is served. He stated that patients are served primarily in the dining room on the 1st floor, but there are times, such as during the first 24 hours when the patient is first admitted and if illness requires isolation, a patient is served on the unit. 2. On 04/03/23 between 2:00 PM and 2:30 PM Surveyor #8 toured units on the 2nd and 3rd floor units with Staff #801. Surveyor #8 observed that Units 3BW and 2AW did not have a posted menu, and Units 2BW, 2BE and 2AE had menus that were not current. 3. On 04/03/23 at 8:30 PM, Surveyor #8 interviewed Staff #801 who acknowledged these menus were not current or absent.

South Sound Behavioral Hospital Plan of Correction for State Licensing or Medicare Hospital/Critical Access Hospital Survey 4/3/2023-4/5/2023

Examination Number: X2023-280 Case Number: 2022-5625 and 2023-3414

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L315- 322-035.1C POLICIES-TREATMENT				
POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients. This Westington Administration	Nursing staff are being retrained (on a one to one basis) on the procedure for rounding as well as all the proper documentation on the rounding sheet. The New Hire Orientation training was	Chief Nursing Officer	4/30/2023	Documented attestation to the training provided for all nursing staff. Any staff member not
treatment of patients; This Washington Administrative Code is not met as evidenced by:	updated to reflect this expectation.	9 8		completing the education by
Based on interview, medical record review, and review		# 12 12 12 12 12 12 12 12 12 12 12 12 12		4/30/23 will be removed from the
of the hospital's policy and procedure, the hospital failed to ensure staff followed the policy on close observation and documentation for 10 of 14		*		schedule
Observation Records reviewed (Patient's #702, #703, #704, #705, #706, #707, #708, #709, #710 and #711).	Unit nurse managers are reviewing the rounding binder during their daily rounds. Additionally, unit nurse managers			Daily Nurse Manager rounding audit and weekly chart audits
Failure to document Physician Ordered Precautions and the patients' observation level can lead to patient elopement or serious risk to patient safety. Findings included:	are auditing 10 charts a week to ensure rounding was completed and documented. The unit RN is signing the rounding sheet rounding sheet to ensure		e san	will be submitted to the CNO. This will be monitored by the CNO for 100%
Document review of the hospital's policy and procedure titled, "Observation Sheet Documentation Guideline" Policy # PC028, last reviewed 07/22 showed	compliance with the documentation.	**************************************		compliance for 3 consecutive months. Any noncompliance
the following: a. The following should be documented every (q) 5 or q15 minutes as ordered: i. The patient's exact location.			,	will be corrected and staff identified will be reeducated.
ii. Pertinent descriptions of the patient's current condition, behavior, or activity.		Britan in A		

Dering by Many Rec. 4124/23
The 10/23/23 App. 4/27/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
iii. Significant patient responses to the care provided by staff. iv. Time that precautions were implemented and discontinued 2. On 04/03/23 at 1:42 PM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the rounding sheets for the patients in the Women's unit. The review showed the following: a. Patient #702 was on q5-minute precautions and was missing 3 q5-minute rounds. b. Patient #703 was on q15-minute rounding and was missing 2 q15 minutes checks. c. Patient #704 was on q15-minute rounding and was missing 4 q15-minute checks. d. Patient #705 was on q15-minute rounding and was missing 4 q15-minute checks. e. Patient #706 was on q15-minute rounding and was missing 10 q15-minute checks. f. Patient #707 was on q15-minute rounding and was missing 16 q15-minute checks. h. Patient #708 was on q15-minute rounding and was missing 16 q15-minute checks. h. Patient #709 was on q15-minute rounding and was missing 4 q15-minute checks. i. Patient #710 was on q15-minute rounding and was missing 4 q15-minute checks. j. Patient #711 was on q15-minute rounding and was missing 6 q15-minute checks. 3. At the time of the review Staff #701 verified 10 of the 14 rounding sheets were missing 2 or more	P! Director will perform random camera checks from the previous night and audits will be documented on random patient rounding audit tool. In addition, Administration/ AOC will do random patient rounding audit tool daily (AOC on weekends).			PI director will collect all Administration/AOC random patient rounding. Weekly data gathered will be discussed during hospital flash. This will be monitored for 100% compliance for 3 consecutive months. Any noncompliance will be corrected and staff identified will be reeducated. After compliance of 3 consecutive months, Random audits will be completed quarterly going forward for sustained compliance with quarterly outcomes Results will be reported by the CNO monthly to the Quality/PI, MedExec and Governing Board

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
		and the state of t		
L1065-322-170.2E TREATMENT PLAN-COMPREHENS	On 4/5/2023, the new master treatment	Chief	4/21/2023	Approved New
WAC 246-322-170 Patient Care	plan form/document was revised to	Medical		Treatment Plan
Services. (2) The licensee shall	ensure that the new form/document will	Officer		Form/Document
provide medical supervision and	reflect the time treatment plan was done	(CMO), Chief	E .	
treatment, transfer, and discharge	and signed. This form was approved by	Nursing		
planning for each patient admitted or	the governing board on 4/21/2023 and	Officer		Attendance to
retained, including but not	will be implemented on 4/24/2023.	(CNO),		scheduled treatment
limited to: (e) A comprehensive		Director of		meeting will be
treatment plan developed within	On 4/21/2023, treatment team	Clinical		documented and
seventy-two hours following admission:	leadership met and reviewed the current	Services	5/1/2023	submitted to the
(i) Developed by a multi-disciplinary	process. The following were decided and	(DCS)		Clinical Services
treatment team with input, when	will be implemented:		· ·	Director. This will be
appropriate, by the patient, family,				monitored for 100%
and other agencies; (ii) Reviewed and	 Providers are now assigned 			compliance for 3
modified by a mental health	specific unit to ensure their			consecutive months.
professional as indicated by the	participation in treatment			Any noncompliance
patient's clinical condition; (iii)	meetings is consistent.			will be corrected
Interpreted to staff, patient, and,	Treatment team meeting			and staff identified
when possible and appropriate, to	schedule was revised to ensure			will be reeducated
family; and (iv) Implemented by	participation from treatment			by the CMO. Results
persons designated in the plan;	team members is in compliance			will be reported by
This Washington Administrative Code is not met	with the approved policy and			the CMO, CNO and
as evidenced by:	procedure.			DCS monthly to the
£1065	Treatment team agenda was revised.			Quality/PI, MedExec and Governing
Item #1 Date and time	4. Clinical services, nursing and			Board .
Based on record review and interview, the	providers were retrained on	}		
hospital failed to ensure that staff members	treatment planning with			
completed the Comprehensive Treatment Plan to	emphasis on completion and			
include the date and time for 5 of 7 records	timelines. The New Hire			Clinical Services
reviewed (Patients #701, #712, #713, #714, and				Director or designee

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
#715).	Orientation training was updated			will do a weekly
Failure to develop and implement an	to reflect this expectation.			audit of 10 charts
individualized, interdisciplinary treatment plan for				focused on meeting
behavioral and medical problems places the				the time
patients at risk for inappropriate, inconsistent, and				requirement of
delayed care, creating the potential for negative			·	treatment plans.
patient outcomes, harm, or death.				This will be
Findings included:				monitored with a
Document review of the policy titled,				threshold of 95%
"Treatment planning" Policy# MS.16, last				compliance for 3
reviewed 01/22, showed the following:				consecutive months.
a. Within 72 hours of admission, the first				Any noncompliance
Treatment Team meeting will be held and the				will be corrected
Master Treatment Plan will be prepared by the				and staff identified
multidisciplinary team and signed by the attending				will be reeducated.
physician.				After compliance of
2. On 04/03/23 at 10:06 AM, Surveyor #7, The				3 consecutive
Nurse Manager (Staff #701), reviewed the				months. Random
medical record of Patient #701. Patient #701 was				audits will be
admitted on 03/30/23 at 6:40 PM. Patient #701				completed quarterly
had a Master Treatment Plan (MTP) dated				going forward for
04/03/23 that did not include the time of the				sustained
provider/staff signature.				compliance with
3. At the time of the review Staff #701 verified				quarterly outcomes.
there was no time documented and no place on		1		Results will be
the form for staff or patients to document a time				reported by the
on the time-sensitive document.				CMO, CNO and DCS
4. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff	·			monthly to the
#701 reviewed the medical record for Patient		·	***************************************	Quality/PI, MedExec
#712 who was admitted on 03/31/23 at 12:25 AM.				and Governing
The review showed the patient had a MTP that				Board.
showed no Psychiatric provider participation.				
5. At the time of the review Staff #701 verified				·
there was no time documented and no place on				
the form for staff or patients to document a time				
on the time-sensitive document.				
6. On 04/04/23 at 11:00 AM, Surveyor #7 and				

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
Staff #701 reviewed the medical record for Patient				
#713 who was admitted on 01/24/23 at				
9:56 PM. The review showed the multidisciplinary				
MTP meeting had no time documented on the				
form.	·			•
7. At the time of the review Staff #701 verified				
there was no place on the form for staff or				
patients to document a time on the time-sensitive document.	·			
8. On 04/04/23 at 11:31 AM, Surveyor #7 and				
Staff #701 reviewed the medical record for				
Patient #714 who was admitted on 03/15/23 at				
1:45 AM. The review showed no time noted on				
the MTP.				
9. At the time of the review Staff #701 verified				
there was no time documented and no place on				
the form for staff or patients to document a time				
on the time-sensitive document.				
10. On 04/04/23 at 1:00 PM, Surveyor #7 and				·
Staff #701 reviewed the medical record for				
Patient #714 who was admitted on 01/27/23 at				
1:40 AM. The review showed no time noted on				
the MTP.				
11. At the time of the review Staff #701 verified				
there was no time documented and no place on				
the form for staff or patients to document a time		•		
on the time-sensitive document.				
12. On 04/04/23 at 3:18 PM, Surveyor #7 and				
Staff #701 reviewed the medical record for				
Patient #715 who was admitted on 02/08/23 at				
12:50 AM. The review showed no time noted on	· ·			
the MTP.				
13. At the time of the review Staff #701 verified				
there was no time documented and no place on the				
form for staff or patients to document a time				
on the time-sensitive document.				
Item #2 Incomplete MTP				

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Targe for Compliance
Based on document review and interview the				
hospital failed to ensure a multi-disciplinary				
treatment team completed the Master Treatment				
Plan (MTP) for 4 of 7 records reviewed, (Patients			-	
#701, #712, #713, and #7 16).				
Failure to ensure the development of a complete				
Comprehensive Treatment Plan for behavioral				
and medical problems places patients at risk for	·			
inappropriate, inconsistent, and delayed				
treatment.				
Findings included:				
1. Document review of the policy titled,				
"Treatment planning" Policy# MS.16, last				
reviewed 01/22, showed the following:				
a. Within 72 hours of admission, the first		•		
Treatment Team meeting will be held and the				
Master Treatment Plan will be prepared by the				.*
multidisciplinary team and signed by the attending				
physician.				
i. Specific departmental strategies are written by				
the individual discipline members.				
ii. Patient goals and staff strategies will be based				
upon assessments conducted and records				
received within the first week of hospitalization.				
b. Goals are established in reference to specified				
problems.	'			
i. Goals are achievable with target dates and written in				
measurable terms. b. Specific				
strategies or treatment modalities will be			-	
identified and the responsible staff/discipline will	·			
be indicated.				
c. The treatment plan, goals, and progress				
toward these goals will be reviewed and revised			•	
by the Treatment Team weekly or more often as				,
clinically indicated.				
2. On 04/03/23 at 10:06 AM, Surveyor #7 and the				
Nurse Manager (Staff #701) reviewed the medical				

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
record for Patient #701 who was admitted on				
03/30/23 at 6:40 PM. Review of the medical				
record showed the following:				
a. Patient #701 had a MTP dated 04/03/23 with				
the following problems listed;				
Psychiatric problems		1		
i. High Risk for Suicide.				
ii. Danger to self with Psychosis.		_		
Medical problems				
iii. Substance-related detox.				
iv. Risk of complication during detox.				
v. Risk for injury related to Seizure.				
vii. Risk of falls.				
viii. Impaired skin integrity.				
ix. Hypertension (HTN).				
x. Chronic pain.				
xi. Insomnia.				
xii. Asthma.				,
xiii. Gerd.				
xiv. Impaired physical mobility.				
xv. Extremity immobilization: cast, limb, joint				
fixation as evidenced by splint on Left leg for				
ankle fracture.				
xvî. HTN.				
b. The Treatment Team was only signed by the				
Program Therapist.				
3. Surveyor #7 interviewed the Program Therapist				
(Staff #702) who stated she was currently				
working on the MTP and had not had an		1		
opportunity to complete it due to the weekend.				
Staff #702 further advised they had not yet held				
the Multidisciplinary Master Treatment meeting.				
4. At the time of the review Staff #701 verified the				
incomplete MTP and that it had not been				
completed within 72 hours of the patient's		1		
admission.				
5. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff				

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
#701 reviewed the medical record for Patient			and the second of the second of the second	and to the state of the state o
#712 who was admitted on 03/31/23 at 12:25 AM.				
The review showed the patient had a MTP that				
showed no Psychiatric provider participation.				
6. At the time of the review Staff #701 verified the				
incomplete MTP and that it had not been				
completed within 72 hours of the patient's				
admission. xi. Insomnia.				
xii. Asthma.				
xiii. Gerd.				
xiv. Impaired physical mobility.				
xv. Extremity immobilization: cast, limb, joint				
fixation as evidenced by splint on Left leg for				
ankle fracture.				
xvi. HTN.	·			
b. The Treatment Team was only signed by the				·
Program Therapist.				
3. Surveyor #7 interviewed the Program Therapist				
(Staff #702) who stated she was currently				· ·
working on the MTP and had not had an				
opportunity to complete it due to the weekend.				
Staff #702 further advised they had not yet held				
the Multidisciplinary Master Treatment meeting.				
4. At the time of the review Staff #701 verified the				
incomplete MTP and that it had not been				
completed within 72 hours of the patient's admission.				
5. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff				
#701 reviewed the medical record for Patient				
#712 who was admitted on 03/31/23 at 12:25 AM.				
The review showed the patient had a MTP that				
showed no Psychiatric provider participation.				
6. At the time of the review Staff #701 verified the				
incomplete MTP and that it had not been		and the state of t		
completed within 72 hours of the patient's				
admission.				
State Form 2567				

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
STATE FORM				
L1100 -322-170.3B PSYCHIATRIC SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (b) Psychiatric services, including: (i) A staff psychiatrist available for consultation daily and visits as necessary to meet the needs of each patient; and (ii) A child psychiatrist for regular consultation when hospital policy permits the admission of children or adolescents;	CEO reached out to child psychiatrist to provide regular consult services to SSBH adolescent provider(s). A contract is estimated to be signed and provider will be credentialed on 5/1/2023	Chief Executive Officer and Chief Medical Officer	5/1/2023	Credentialed child psychiatrist will be on staff on 5/1/2023
This Washington Administrative Code is not met as evidenced by: . Based on interview, and document review the hospital failed to ensure that a child psychiatrist is available for regular consultation when hospital policy permits the admission of children or adolescents. Failure to have a child psychiatrist available for consultation when the hospital has children or adolescent patients puts these patients at risk of receiving incomplete treatment. Reference: WAC 246 322 010 Definitions: (7) "Child psychiatrist" means an individual licensed as a physician under chapter 18.71 or 18.57 RCW who is board-certified or board-eligible with a specialty in child psychiatry by: (a) The American Board of Psychiatry and Neurology; or (b) The Bureau for Osteopathic Specialists,				

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
Findings included: 1. On 04/03/23 at 8:30 AM, Surveyor #8, Surveyor #10, and Surveyor #7 interviewed the CEO (Staff #803) about the provision of adolescent services at the hospital. Staff #803 stated that the 2nd floor the hospital has an adolescent unit. 2. On 04/05/23 at 10:15 AM, the Medical Director (Staff #802) was interviewed by Surveyor #8, Surveyor #10, and Surveyor #7. During the interview, Staff #802 stated that to be a child psychiatrist requires specialized and additional medical training. He stated that he is not aware of anyone with child psychiatry training currently privileged to provide consultation at South Sound Behavioral Hospital.	On 4/17/2022 the Activities Manager			
L1295 322-200.3L RECORDS-PROGRESS NOTES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (I) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities; This Washington Administrative Code is not met	On 4/17/2023, the Activities Manager revisited schedule for recreational therapy assessments and staff assignments. Policy and procedure was reviewed. Activity therapists were educated on the 72H requirement of activity assessment. The New Hire Orientation training was updated to reflect this expectation.	Activity Therapy Manager	4/21/2023	Documented attestation to the training provided for all staff in activity therapy department. Any staff member not completing the education by 4/30/23 will be removed from the schedule
as evidenced by: L1295 . Based on document review and interview, the hospital failed to ensure prompt entry of initial recreational therapy assessments in the medical record for 3 of 6 patients reviewed (Patient #1004, #1005, and #1006).	A tracker was designed to ensure compliance and meeting the necessary time requirement which will be utilized by the activity department. Activity Therapy Manager will monitor compliance of timely assessment and completion of documentation.			Activities Manager or designee will do a weekly audit of 10 charts on the timeliness of the recreational therapy assessment. This will be monitored for

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Failure to document initial assessments risks				95% compliance for
patient harm from unrecognized or unmet care				3 consecutive
needs, and inconsistent and unsafe care due to				months. Any
an incomplete medical record.				noncompliance will
Findings included:				be corrected and
1. Document review of the hospital's policy titled,				staff identified will
"Activity Therapy Assessment of Patients," no				be reeducated.
policy number, reviewed 01/22, showed:				Random audits will
a. All patients admitted to South Sound				be completed
Behavioral Hospital will receive a thorough				quarterly going
assessment and evaluation. Results of				forward for
assessments are reviewed and integrated by the				sustained
multidisciplinary treatment team to prioritize				compliance with
identified problems within the interdisciplinary				quarterly outcomes.
treatment plan.				Results will be
b. Activity Therapy Assessment: This assessment				reported by the
is completed within 72 hours of admission and				Activity Therapy
includes (in part) information regarding the				Manager monthly to
patient's diagnosis and orders received; physical				the Quality/PI,
restrictions and precautions; attitude and affect;				MedExec and
decision-making/problem solving skills; social	· ·			Governing Board
skills; communication and coping skills;				
concentration; insight; and leisure skills.	·			
Summary contents including brief history,				
educational needs, precipitating event, and an				
individualized treatment plan are also included.				
2. On 04/04/23 at 1:30 PM, Surveyor #10 and the	·		·	
Chief Nursing Officer (Staff #1001) reviewed the				
medical records for Patients #1004, #1005, and				
#1006. The review showed the following:				
a. Patient #1004 was admitted on 03/04/23 at				
4:40 PM. Surveyor #10 found no evidence that an				-
activity therapy assessment had been completed				
within 72 hours.				
b. Patient #1005 was admitted on 03/03/23 at				
8:00 PM. Surveyor #10 found no evidence that an				
activity therapy assessment had been completed				

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within 72 hours.				
c. Patient #1006 was admitted on 02/09/23 at				
8:00 PM. Surveyor #10 found no evidence that an				
activity therapy assessment had been completed				
within 72 hours.				
5. At the time of the record reviews, Staff #1001				
verified there was no documentation of initial				
activity therapy assessments in the medical				
records of Patient #1004, #1005, and #1006.				
6. At the time of the record reviews, Surveyor #10				
interviewed the Director of Clinical Services (Staff				
#1002) about the responsibilities of recreational			·	
therapists. Staff #1002 confirmed that the recreational therapist is to complete an initial				
activity assessment of each patient within 72				
hours of admission.				
L1390 322-210.3F PROCEDURES-AUTHENTICATE	Retraining of providers on authentication	CMO and	4/20/2023	Documented
LEGGO GEL ELGIGI I MOCEDONES AGINEMANONIE	of orders was completed on 4/20/2023.	Director of	4/20/2023	attestation to the
WAC 246-322-210 Pharmacy and Medication Services.	The New Provider Orientation training	Pharmacy		training provided for
The licensee shall: (3) Develop and implement	was updated to reflect this expectation.			all providers. Any
procedures for prescribing, storing, and administering	,			provider not
medications according to state and federal laws and				completing the
rules, including: (f) Authenticating verbal and telephone	RN chart check was revised to include	CNO		education by
orders by prescriber in a timely manner, not to exceed	check of providers authentication of			4/30/23 will be
forty-eight hours for inpatients; This Washington	order made within 24 hours.		-	removed from the
Administrative Code is not met as evidenced by:		4		schedule
Based on interview and document review, the hospital				Director of
failed to ensure prompt filing into the clinical record of				Pharmacy will
provider clinical record of provider authentication for				perform random
telephone orders and verbal orders for 7 of 16 patients			1	audits monthly on
(Patients #701, #713, #714, #715, #1001, #1002, and				timely
#1003).				authentication of
				orders (48 hours).
Failure to authenticate orders promptly puts patients at				This will be
risk of harm from improper care and medical error.				monitored by the
				Director of

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
Findings included: 1. Document review of the hospital policy titled, "Medication Ordering and Prescribing," policy number PH 022, last reviewed 1/22, showed that telephone orders must be co-signed by the physician within 24 hours. Document review of the hospital policy titled, "Physician Orders," policy number RC 001, last reviewed 1/22, showed the following: a. Purpose: to provide guidelines for processing orders. b. All physician orders shall be written [in the] electronic medical record system. c. All telephone orders entered directly into the electronic medical record system by a nurse must be co-signed by the ordering physician within 48 hours after entry. 2. On 04/03/23 at 10:06 AM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the medical record for Patient #701 who was admitted on 03/30/23 at 6:40 PM. Review of the medical record showed the following: a. A telephone order for a dietary consult and a Clinical Institute Withdrawal Assessment (CIWA) Scale order was placed on 03/30/23 at 10:40 PM by a Registered Nurse (RN) (Staff #702) and authenticated by the provider on 04/03/23 at 9:54 AM, 83 hours and 34 minutes after the order was placed. b. A telephone order for the medication, Albuterol 90mcg inhalation, was placed on 03/31/23 at 1:07 PM by an RN (Staff #703) and authenticated by the provider on 04/03/23 at 9:54 AM, 68 hours and 47 minutes after the order was placed.				Pharmacy for 95% compliance for 3 consecutive months. Any noncompliance will be corrected and provider identified will be reeducated. Director of Pharmacy and CMO are responsible for monitoring follow-up and reeducation needed. After stated compliance is achieved for 3 consecutive months, random audits will be completed quarterly Results will be reported by the CMO monthly to the Quality/PI, MedExec and Governing Board .

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
3. At the time of the review Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN and the dietary consult and CIWA scale orders were not authenticated within 48 hours.				
4. On 04/03/23 at 2:30 PM, Surveyor #10 and the Chief Nursing Officer (Staff #1001) reviewed the electronic medical record for Patient #1001. The review showed:				
a. An order entered by an RN for amlodipine 5mg on 01/19/22 was not co-signed by a provider until 02/17/22 (29 days).				
b. An order entered by an RN for vital signs on 02/20/22 was not co-signed by a provider until 03/25/22 (34 days).			·	
c. An order entered by an RN for transfer on 03/04/23 was not co-signed by a provider until 03/10/23 (6 days).				
5. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe.				
6. On 04/04/23 at 11:00 AM, Surveyor #7 and Staff 701 reviewed the medical record for Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the following:				
a. A medication order for Culturelle was placed on 01/26/23 at 4:17 PM by an RN (Staff #704).				
b. A medication order for Calcium Carbonate 500 mg was placed on 01/28/23 at 4:47 PM by an RN (Staff #705).		. ,	!	
7. At the time of the review, the order for Culturelle and Calcium Carbonate had not been authenticated by a provider.			1	

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a. At the time of the review, Staff #701 verified the nedication order was not authenticated within 24 yours after being placed by an RN.	·		·	
9. On 04/04/23 at 11:31 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 03/15/23 at 1:45 AM. The review showed the following:				
a. A medication order for transdermal nicotine was placed on 03/18/23 at 10:51 AM, by an RN (Staff #705).				
b. A medication order for Quetiapine oral 100 mg was placed on 03/18/23 at 10:53 AM, by Staff #705. c. A medication order for Quetiapine oral 300 mg was placed on 03/18/23 at 10:54 AM, by Staff #705.				
10. At the time of the review the 3 medication orders had not been authenticated.				www.mming-t-lanes-grade-of-defi-
11. At the time of the review, Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN.				
12. On 04/04/23 at 11:45 AM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1002. The review showed: a. An order entered by an RN for transfer on 03/22/23 had not been co-signed by a provider at the time of the review (13 days).				
b. An order entered by an RN for discharge to higher level of care on 03/22/23 had not been co-signed by a provider at the time of the review (13 days).				A CORRESPONDE MANAGEMENT AND A CORRESPONDED AND A C

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
13. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe.				
14. On 04/04/23 at 1:30 PM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1003. The review showed an order entered by an RN for wound care consult on 02/11/23 was not cosigned by a provider until 02/15/23 (4 days).				
15. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe.				
16. On 04/04/23 at 1:41 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #715 who was admitted on 01/27/23 at 1:40 AM. The review showed the following:				
a. A medication order for Albuterol inhalation was placed on 01/27/23 at 3:20 AM, by an RN (Staff #706). The order was authenticated on 03/03/23 at 2:06 PM, 6 days after being placed by the RN.				
17. At the time of the review Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN.	·			
L1525 322-230.2H FOOD SERVICE-MENU PLANNING WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (h) Ensuring all menus: (i) Are written at least one week in advance; (ii) Indicate the date day of week month and years (iii)	Policy and procedure reviewed and revised on 4/21/2023 to reflect the new process for ensuring menu are updated weekly. All dietary staff were reeducated on the new policy and procedure.	Food Services/ Dietary Manager	4/21/2023	Documented attestation to the training provided for all dietary staff. Any staff member not completing the education by
Indicate the date, day of week, month and year; (iii) Include all foods and snacks served that contribute to				4/30/23 will be

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Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
nutritional requirements; (iv) Provide a variety of foods;				removed from the
(v) Are approved in writing by the dietitian; (vi) Are				schedule
posted in a location easily accessible to all patients; and				
(vii) Are retained for one year; This Washington	,	The state of the s		
Administrative Code is not met as evidenced by:				Dietary manager or
				its designee will
Based on observation, interview and document review,				audit weekly on
the hospital failed to ensure that patient menus were		The state of the s		posting of new
posted in a location easily accessible to all patients.		Ì		menus in patient
				care units. This will
Failure to provide a menu that is easily accessible		1		be monitored by the
restricts the patient's ability to select their dietary				dietary manager for
options. This inability to select dietary options puts		100		100% compliance for
patients at risk of harm from inadequate nutrition.				3 consecutive
		- Carrier of the Carr		months. Random
Findings included:				audits will be
				completed quarterly
1. On 04/03/23 between 10:00 AM and 11:00 AM,				going forward for
Surveyor #8 toured units on the 2nd and 3rd floors with				sustained
Infection Preventionist (Staff #801). Staff #801 was				compliance with
interviewed regarding where food is served. He stated			-	quarterly outcomes.
that patients are served primarily in the dining room on)		Any noncompliance
the 1st floor, but there are times, such as during the				will be corrected.
first 24 hours when the patient is first admitted and if			VIII.	After stated
illness requires isolation, a patient is served on the unit.	·			compliance is
			7 P. C.	achieved for 3
2. On 04/03/23 between 2:00 PM and 2:30 PM			Ì	consecutive months,
Surveyor #8 toured units on the 2nd and 3rd floor units		-		random audits will
with Staff #801. Surveyor #8 observed that Units 3BW				be completed
and 2AW did not have a posted menu, and Units 2BW,				quarterly Results will
2BE and 2AE had menus that were not current.		-		be reported by the
			_	dietary manager
3. On 04/03/23 at 8:30 PM, Surveyor #8 interviewed				monthly to the
Staff #801 who acknowledged these menus were not				Quality/PI, MedExec
current or absent.				and Governing
		•		Board

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Submitted by:

Terrance O'Reilly

Chief Executive Officer

South Sound Behavioral Hospital Date: 4/24/93



10/11/23

Ms. Navarete Smokey Point Behavioral Hospital

Dear Ms. Navarete

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at South Sound Behavioral Hospital on 06/27/23 to 06/29/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 08/03/23.

Hospital staff members sent a Progress Report dated 10/10/23 that indicates all deficiencies have been corrected. The Department of Health accepts South Sound Behavioral's attestation to be in compliance with Chapter 246-320 WAC.

If there were fire life safety deficiencies identified in your report, the Deputy Fire Marshal will perform an on-site revisit after the correction date to verify those corrections.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Marnie Rathbun Survey Team Leader