State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: ______ B. WING ______	C 12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SOUND BEHAVIORAL HOSPITAL	605 WOODLAND SQUARE LOOP SE LACEY, WA 98503

(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) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC), 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. On-site dates: 12/04/23-12/06/23 Case number: 2023-9228 Intake number: 132908 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on 12/31/23. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 365	322-035.1M POLICIES-PATIENT PROPERTY 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	L 365		

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L 365	Continued From page 1	L 365		

services provided: (m) Responsibility
for patients' personal property,
including recording any valuables left
on deposit with the hospital;
This Washington Administrative Code is not met
as evidenced by:

Based on interview, record review, and review of the hospital's policies and procedures, the hospital failed to ensure that patients' personal property was secured during their stay for 4 of 6 patients reviewed (Patients #1, #2, #4, and #5).

Failure to ensure the patient's property is secure during the patient's stay may result in patients losing valuables and necessary items, leaving patients vulnerable to lack of identification, money, or weather-suitable clothing.

Findings included:

1. Review of the policy titled, "Inventory and Storage of Patient Belongings," policy number #PC004, last reviewed 08/21, showed that staff are required to perform and document an itemized list of patient belongings during the admission process. Whenever possible, the patient should be present during the process. When finished, the patient and the staff member completing the inventory will sign and date the Inventory of Patient Belongings form. If the patient is unable to participate, two staff members will complete the inventory process and sign the form. Items should be inventoried and listed individually on the Inventory of Patient Belongings form and then secured. The document is then placed in the discharge planning section of the chart. When the patient is discharged, a Mental Health Technician (MHT) collects the patient's belongings and inventories them again in the

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L 365	Continued From page 2	L 365		

presence of the patient. Both the MHT and the patient sign the document again to show that the patient received their items.

2. On 12/06/23 at 2:30 PM, an interview with a Registered Nurse (RN) (Staff #1) showed that during the admission process, patient belongings are itemized and documented on the Inventory of Patient Belongings form, including the contents of wallets.

3. On 12/06/23 at 2:45 PM, an interview with an MHT (Staff #2) showed that staff should complete the Inventory of Patient Belongings form for every patient during the admission process, even if they do not have any personal belongings with them. If a patient transfers from an acute care Emergency Department (ED) without any personal belongings, staff will call the ED to find out if the patient had items that were not returned at discharge.

4. The investigator reviewed the medical records of 6 patients admitted to the facility between 06/13/22 and 11/07/23. The review showed the following:

a. Patient #1 was admitted to the facility on 06/13/22 and discharged on 09/27/22. A review of the Inventory of Patient Belongings form showed that Patient #1 signed the form upon admission to the facility on 06/14/22, and at discharge on 09/27/22. There were no staff signatures on the document showing who performed the initial inventory or who released the belongings to the patient as required by hospital policy.

b. Patient #2 was admitted to the facility on 09/14/22 and discharged on 09/23/22. The investigator found no evidence that staff

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L 365	Continued From page 3 completed an Inventory of Patient Belongings form at any time during Patient #2's hospitalization as required by hospital policy. c. Patient #4 was admitted to the facility on 11/14/22 and discharged on 11/21/22. The Inventory of Patient Belongings form showed that the patient had "clothes and hoodies" on admission. Staff failed to document an itemized list of patient belongings, and there was no staff signature showing who returned the items to the patient at discharge, as required by hospital policy. d. Patient #5 was admitted to the facility on 11/07/23. A review of the Inventory of Patient Belongings form, dated 11/08/23, showed an itemized list of patient belongings, but there were no patient or staff signatures as required by hospital policy. 5. On 12/06/23 at 5:25 PM, an interview with the Chief Executive Officer (CEO) (Staff #7) showed if a patient is admitted without any personal belongings, there should be documentation on the Inventory of Patient Belongings form to show that the patient did not have belongings. During the interview, Staff #7 confirmed the investigator's findings of the missing documentation for Patients #1, #2, #4, and #5. .	L 365		
L1080	322-170.2H DISCHARGE PLAN WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or	L1080		

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retained, including but not limited to: (h) A discharge plan including a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care;
This Washington Administrative Code is not met as evidenced by:

Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that patients with suicidal ideation met the criteria for discharge for 1 of 6 patient records reviewed (Patient #2) (item #1), and the hospital failed to adopt and implement policies and procedures to ensure an appropriate discharge plan for 2 of 4 patients with access to firearms (Patients #2 and #3) (item #2).

Failure to ensure that patients with suicidal ideation meet the criteria for discharge, and failure to adopt and implement policies and procedures to ensure that patients with access to firearms receive an appropriate discharge plan places patients and the community at risk of serious physical and psychological harm, including death.

Item #1: Discharge Criteria

1. Review of the policy titled, "Admission, Discharge, and Continued Stay Criteria," policy number #PC005, last revised 04/22, showed that discharge criteria include reaching the goals of treatment at the current level of care, having follow up goals and a treatment plan for lesser levels of care, and that releasing the patient to a lesser level of care will not pose a threat to the patient, others, or property.

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Review of the policy titled, "Discharge Criteria," policy number #MS:04, last revised 05/22, showed that medical staff use the following criteria to determine readiness for discharge: the patient is not an immediate risk to self or others; the patient is able to benefit from treatment in a less restrictive setting; and all appropriate goals for treatment in the hospital have been obtained.

Review of the policy titled, "Suicide Precautions," policy number #PC006, last reviewed 04/22, showed that upon admission, Assessment and Referral (A&R) Clinicians identify and assess a patient's risk of suicidal ideation using the Columbia Suicide Severity Rating Scale (CSSRS), report any suicidal ideation to the provider, and initiate appropriate interventions to ensure patient safety. The document showed that the precautions stay in effect until they are discontinued by a written order and the provider documents no further need for the precautions. The RN ensures that the patient remains on suicide precautions until the attending provider writes the order to discontinue the precautions.

Review of the policy titled, "Discharge Planning," no policy number, last reviewed 01/22, showed that the discharge plan should identify problems to be addressed in the next level of care and identify the individual(s) responsible for ensuring that the prescribed follow-up is accomplished.

2. On 12/06/23 at 3:15 PM, an interview with the Director of A&R (Staff #6) showed that all patients initially start their stay with Q5 observations (visualizing the patient every 5 minutes to assess safety). A&R treats the inability to assess suicide risk in a patient as a positive finding, indicating that the patient will be treated as a suicide risk until further assessment shows that the suicide

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risk is resolved. Staff #6 stated that at discharge, staff members consider existing supports and resources when assessing suicide risk.

3. On 12/06/23 at 4:30 PM, an interview with a Discharge Planner (Staff #4) showed that any suicidal ideation identified at discharge is reported to the provider to see what the provider wants to do. Staff #4 stated that discharge can be canceled if a patient presents with suicidal ideation at the time of discharge.

4. On 12/06/23 at 2:00 PM, an interview with an Advanced Registered Nurse Practitioner (ARNP) (Staff #5) showed that suicidal ideation at discharge is not always exclusionary and is determined on a case-by-case basis. Staff #5 stated that the provider looks at family support and any history of chronic suicidal ideation to identify protective factors for suicide risk at discharge. Staff #5 stated that suicide precautions need to be discontinued before the patient can be discharged.

5. Review of the medical record showed that Patient #2 was a 52-year-old man voluntarily admitted on 09/14/22 for suicidal ideation, depression, severe alcohol use, and complicated grief after recently losing his son to suicide. Review of the patient's Master Treatment Plan, dated 09/15/22, showed that the patient should exhibit no suicidal ideation for 48 hours prior to discharge. The area of the Treatment Plan showing that an identified goal was attained, revised, canceled, or continued was blank, and there was no documented resolution of any problems or achievement of any goals prior to discharge. The investigator found no documentation showing the goal was met, revised, or canceled at anytime prior to Patient

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#2s discharge.

A review of Psychiatric Daily Progress Notes showed that the final Psychiatric Daily Progress Note, dated 09/22/22, showed that the patient endorsed suicidal ideation without a plan. The note showed that the treatment plan was for Patient #2 to remain hospitalized for stabilization and a sustainable discharge plan. The provider listed suicide ideation as one of Patient #2's barriers to discharge. Under "Mental Status Exam" within the same note, the provider documented showed that Patient #2 was a suicide risk and was experiencing suicidal ideation. Under the section titled, "Justification for Continued Stay," boxes were checked for continued behavior intolerable to patient or society with high probability of the behavior recurring if the patient were to be discharged.

Review of orders and observation sheets showed that on 09/19/22 at 2:00 PM, the provider ordered suicide precautions with Q5 observations. On 09/23/22 at 9:45 AM, Observation sheet documentation showed that the patient was still on suicide precautions with Q5 minute observations. On 09/23/22 at 10:00 AM, Patient #2 was discharged from the facility. The investigator found no evidence showing that the provider discontinued the orders for suicide precautions or Q5 observations before the patient was discharged.

6. On 12/06/23 at 5:25 PM, an interview with the CEO (Staff #7) showed that a patient could be discharged with passive suicidal ideation, and that active suicidal ideation would indicate not having met the discharge criteria. Staff #7 stated that suicide precautions are implemented for patients whose suicidal ideation is active rather

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than passive. When asked about Patient #2's Treatment Plan goal of being free of suicidal ideation for 48 hours prior to discharge, Staff #7 stated that he was unfamiliar with that being used as a treatment goal and that the Treatment Plan goal was probably amended. Staff #7 stated that if patients are reassessed at discharge as low risk for suicide, they can be released, regardless of the patient's previous suicidal ideation.

7. Upon chart review with the investigator, Staff #7 stated that he did not see any addendum or amendment showing that the goal was met or discontinued. Staff #7 confirmed the investigator's findings that at the time of discharge, Patient #2 was experiencing suicidal ideation, had active orders for suicide precautions with Q5 observations, and did not meet his Treatment Plan goals.

Item #2: Access to Firearms

1. Review of the document titled, "Intake Assessment," showed that the patient is asked if they have access to guns or lethal methods at intake. Review of the document titled, "Discharge and Transition Plan," showed that staff asks the patient "are there guns in the home?" and inquires if any guns that may have been in the home have been removed and by whom.

2. Review of policies and procedures showed that the hospital did not have a policy or procedure for discharging voluntary patients with access to guns.

3. On 12/06/23 at 6:00 PM, an interview with the Director of Risk Management (Staff #8) showed that the hospital did not have a defined policy or procedure that guided staff on discharging

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voluntary patients with access to firearms. Staff #8 stated that the hospital considers it a best practice to ask all patients about firearms at intake, when safety planning, and at discharge.

4. On 12/06/23 at 1:30 PM, an interview with the Director of Assessment and Referral (A&R) (Staff #6) showed that all staff have access to the intake assessment, and that they should resolve any conflicts between the intake and discharge gun access statements with documentation of the removal or withdrawal of access by a friend or family member. She stated that the patient would need to cooperate with safety planning in relation to the possession of or access to a gun in order to be discharged. She stated that they would call the Designated Crisis Responder (DCR) for an assessment for involuntary treatment if a patient did not cooperate with the safety plan related to weapons.

5. On 12/06/23 at 4:30 PM, an interview with a Discharge Planner (Staff #4) showed that she arranges the discharge plan and reports any guns to the Program Therapist and the provider.

6. The investigator reviewed the medical records of 4 patients admitted to the facility between 06/13/22 and 11/07/23. The review showed the following:

a. Patient #2 was a 52-year-old man voluntarily admitted on 09/14/22 for suicidal ideation, depression, severe alcohol use, and complicated grief after recently losing his son to suicide. A review of the Intake Assessment, dated 09/14/22, showed that the hospital A&R staff asked the patient if he had access to guns and if there were prior suicide attempts. Intake documentation showed that the patient had access to a gun at

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L1080	Continued From page 10 his deceased son's house and had attempted suicide multiple times. The Discharge and Transition Plan, dated 09/23/22, showed that the patient was asked if there were guns in the home. The documentation showed that the patient denied having guns in the home. The documentation showed that Patient #2 denied having guns in the home, and staff documented that the patient denied having access to guns. There was no documentation showing that the gun referenced in the intake document was removed or secured. b. Patient #3 was a 43-year-old woman admitted voluntarily on 09/19/22 for Post Traumatic Stress Disorder (PTSD) and depression related to her previous military deployment and combat status. The Intake Assessment, dated 09/19/22, showed that the hospital A&R staff asked the patient if she had access to guns and if she had any history of suicide attempts. The document showed that staff marked "yes" to both questions; in the text boxes to the side of the checkboxes, staff wrote "denies" for both questions. There was no documentation explaining the discrepancy. The Discharge and Transition Plan, dated 09/24/22, showed that Patient #3 denied having guns in the home. There was no documentation showing that staff asked the patient about the discrepancy between the intake document and the discharge document. The Discharge and Transition Plan, dated 09/24/22, showed that the patient denied having guns in the home. No documentation showed that staff asked the patient about the discrepancy between the discharge document and the intake document. 7. On 12/06/23 at 5:25 PM, the investigator interviewed the Chief Executive Officer (Staff #7) about the inconsistencies between the intake and	L1080		

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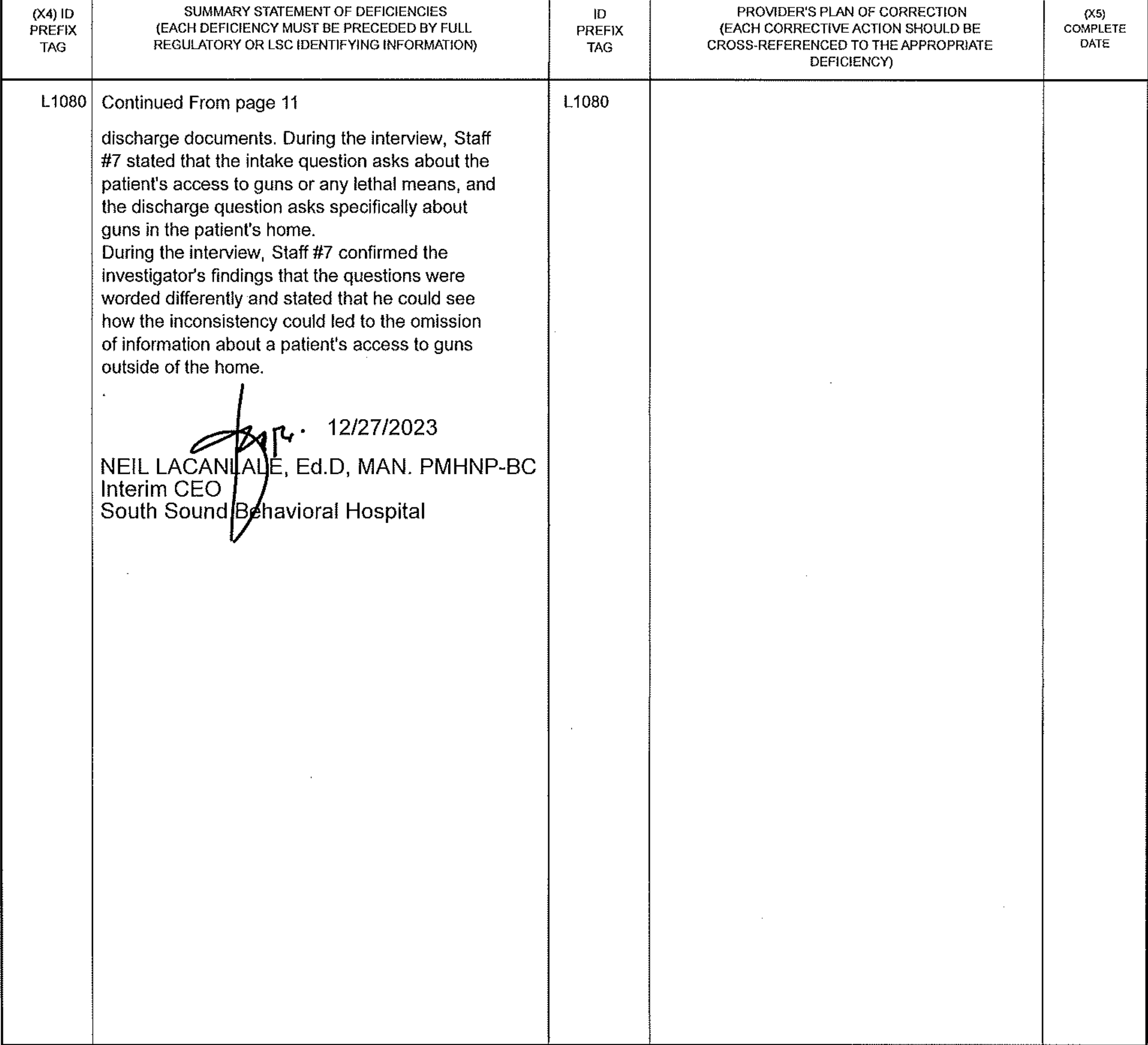

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L1080	Continued From page 11 discharge documents. During the interview, Staff #7 stated that the intake question asks about the patient's access to guns or any lethal means, and the discharge question asks specifically about guns in the patient's home. During the interview, Staff #7 confirmed the investigator's findings that the questions were worded differently and stated that he could see how the inconsistency could led to the omission of information about a patient's access to guns outside of the home.	L1080		

12/27/2023

NEIL LACANLALE, Ed.D, MAN. PMHNP-BC
Interim CEO
South Sound Behavioral Hospital

South Sound Behavioral Hospital
Plan of Correction
12/4/23-12/6/2023
Intake Number: 132908
Case Number: 2023-9228

POC rec'd 12/27/23, revised 12/28/23 approved 12/28/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 365 322-035.1M POLICIES-PATIENT PROPERTY 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: (m) Responsibility for patients' personal property, including recording any valuables left on deposit with the hospital; This Washington Administrative Code is not met as evidenced by:				
Based on interview, record review, and review of the hospital's policies and procedures, the hospital failed to ensure that patients' personal property was secured during their stay for 4 of 6 patients reviewed (Patients #1, #2, #4, and #5). Failure to ensure the patient's property is secure during the patient's stay may result in patients losing valuables and necessary items, leaving patients vulnerable to lack of identification, money, or weather-suitable clothing.	South Sound Behavioral Hospital is committed to providing quality care to its patients. With these opportunities for improvement, SSBH team will: 1. Policy and Procedure on Inventory and Storage of Patient Belongings was reviewed and updated.	Interim CEO	12/27/2023	Approved revised form, policy & procedure on Inventory and Storage of Patient Belongings
	Policy update includes the following:	Interim CEO	12/27/2023	
Findings included: 1. Review of the policy titled, "Inventory and Storage of Patient Belongings," policy number #PC004, last reviewed 08/21, showed that staff are required to perform and document an itemized list of patient belongings during the admission process. Whenever possible, the patient should be present during the process. When finished, the patient and the staff member completing the inventory will sign and date the Inventory of Patient Belongings	Weapons i. The treatment team will make the final decision if weapons may be returned to the patient. 1. Any involuntary or ITA	CNO, A&R Director, Clinical Services Director	1/19/2023	Documented attestation to the training provided for all admissions & referral staff and nursing staff. Any staff member not

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form. If the patient is unable to participate, two staff members will complete the inventory process and sign the form. Items should be inventoried and listed individually on the Inventory of Patient Belongings form and then secured. The document is then placed in the discharge planning section of the chart. When the patient is discharged, a Mental Health Technician (MHT) collects the patient's belongings and inventories them again in the presence of the patient. Both the MHT and the patient sign the document again to show that the patient received their items. 2. On 12/06/23 at 2:30 PM, an interview with a Registered Nurse (RN) (Staff #1) showed that during the admission process, patient belongings are itemized and documented on the Inventory of Patient Belongings form, including the contents of wallets. 3. On 12/06/23 at 2:45 PM, an interview with an MHT (Staff #2) showed that staff should complete the Inventory of Patient Belongings form for every patient during the admission process, even if they do not have any personal belongings with them. If a patient transfers from an acute care Emergency Department (ED) without any personal belongings, staff will call the ED to find out if the patient had items that were not returned at discharge. 4. The investigator reviewed the medical records of 6 patients admitted to the facility between 06/13/22 and 11/07/23. The review showed the following: a. Patient #1 was admitted to the facility on 06/13/22 and discharged on 09/27/22. A review of the Inventory of Patient Belongings form showed that Patient #1 signed the form upon admission to the facility on 06/14/22, and at discharge on 09/27/22. There were no staff signatures	patients are not permitted to keep weapons. ii. If the patient is not authorized to keep the weapons 1. The patient may notify a family member to pick up the weapon at Lacey PD. 2. All unclaimed belongings will be kept for 30 days past the discharge date then disposed of at the discretion of SSBH leadership. 2. Inventory of Patient Belongings form was updated to ensure documentation when patient is admitted to SSBH without belongings to account for. 3. Retrain all admissions & referral and nursing staff on patient belongings and storage			completing the education by 1/19/2023 will be removed from the schedule. New employee orientation was revised to ensure consistent training of all new staff by 1/15/2023. CNO and A&R Director or its designee will complete an audit for 3 consecutive months with a 95% threshold of compliance. For non-compliance the CNO and A&R Director or its designee will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education. All data gathered will be presented to the quality assurance and performance

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on the document showing who performed the initial inventory or who released the belongings to the patient as required by hospital policy. b. Patient #2 was admitted to the facility on 09/14/22 and discharged on 09/23/22. The investigator found no evidence that staff completed an Inventory of Patient Belongings form at any time during Patient #2's hospitalization as required by hospital policy. c. Patient #4 was admitted to the facility on 11/14/22 and discharged on 11/21/22. The Inventory of Patient Belongings form showed that the patient had "clothes and hoodies" on admission. Staff failed to document an itemized list of patient belongings, and there was no staff signature showing who returned the items to the patient at discharge, as required by hospital policy. d. Patient #5 was admitted to the facility on 11/07/23. A review of the Inventory of Patient Belongings form, dated 11/08/23, showed an itemized list of patient belongings, but there were no patient or staff signatures as required by hospital policy. 5. On 12/06/23 at 5:25 PM, an interview with the Chief Executive Officer (CEO) (Staff #7) showed if a patient is admitted without any personal belongings, there should be documentation on the Inventory of Patient Belongings form to show that the patient did not have belongings. During the interview, Staff #7 confirmed the investigator's findings of the missing documentation for Patients #1, #2, #4, and #5.	The training will highlight on completing and proper documentation of inventories upon admission and discharge including patient and staff signatures.			improvement committee.
L1080 322-170.2H DISCHARGE PLAN WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and	After careful review of the statement of deficiency, the following will be			

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discharge planning for each patient admitted or retained, including but not limited to: (h) A discharge plan including a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that patients with suicidal ideation met the criteria for discharge for 1 of 6 patient records reviewed (Patient #2) (item #1), and the hospital failed to adopt and implement policies and procedures to ensure an appropriate discharge plan for 2 of 4 patients with access to firearms (Patients #2 and #3) (item #2). Failure to ensure that patients with suicidal ideation meet the criteria for discharge, and failure to adopt and implement policies and procedures to ensure that patients with access to firearms receive an appropriate discharge plan places patients and the community at risk of serious physical and psychological harm, including death. Item #1: Discharge Criteria 1. Review of the policy titled, "Admission, Discharge, and Continued Stay Criteria," policy number #PC005, last revised 04/22, showed that discharge criteria include reaching the goals of treatment at the current level of care, having follow up goals and a treatment plan for lesser levels of care, and that releasing the patient to a lesser level of care will not pose a threat to the patient, others, or property. Review of the policy titled, "Discharge Criteria," policy number #MS:04, last revised 05/22, showed that medical	implemented to ensure process improvement and quality care: 1. Reviewed and updated suicide precaution and inventory of patient belongings policy & procedure to highlight process to address patients access to weapon. Policy update includes the following: Address access to weapon before discharge as outlined in the inventory and storage of patient belongings policy and procedure 2. Revised Intake assessment to ensure consistent verbiage of assessments are utilized during admission and before discharge. 3. All clinicians and nurses will be retrained on treatment planning highlighting on the following: a) Intake forms b) Discharge criteria c) Treatment plan update d) Documentation of treatment plan progress e) Reassessment of access to weapons at home at discharge noted on discharge transition plan. f) Documentation of clinicians on securing weapons at home for voluntary patients on	Interim CEO Interim CEO and A&R Director CNO, A& R Director and Clinical Services Director CNO and Clinical Services Director	12/27/2023 12/27/2023 1/19/2023 1/19/2023	Approved revised form, policy & procedure on Inventory and Storage of Patient Belongings Approved revised intake assessment form. Documented attestation to the training provided for all admissions & referral staff, clinicians and nursing staff. Any staff member not completing the education by 1/19/2023 will be removed from the schedule. New employee orientation was revised to ensure consistent training of all new staff by 1/15/2023. CNO and A&R Director or its designee will

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staff use the following criteria to determine readiness for discharge: the patient is not an immediate risk to self or others; the patient is able to benefit from treatment in a less restrictive setting; and all appropriate goals for treatment in the hospital have been obtained. Review of the policy titled, "Suicide Precautions," policy number #PC006, last reviewed 04/22, showed that upon admission, Assessment and Referral (A&R) Clinicians identify and assess a patient's risk of suicidal ideation using the Columbia Suicide Severity Rating Scale (CSSRS), report any suicidal ideation to the provider, and initiate appropriate interventions to ensure patient safety. The document showed that the precautions stay in effect until they are discontinued by a written order and the provider documents no further need for the precautions. The RN ensures that the patient remains on suicide precautions until the attending provider writes the order to discontinue the precautions. Review of the policy titled, "Discharge Planning," no policy number, last reviewed 01/22, showed that the discharge plan should identify problems to be addressed in the next level of care and identify the individual(s) responsible for ensuring that the prescribed follow-up is accomplished. 2. On 12/06/23 at 3:15 PM, an interview with the Director of A&R (Staff #6) showed that all patients initially start their stay with Q5 observations (visualizing the patient every 5 minutes to assess safety). A&R treats the inability to assess suicide risk in a patient as a positive finding, indicating that the patient will be treated as a suicide risk until further assessment shows that the suicide risk is resolved. Staff #6 stated that at discharge, staff members consider existing supports and resources when assessing suicide risk.	the discharge transition plan. 4. All clinicians, nurses and providers will be reeducated on suicide precautions and highlight on the access to guns or weapons at home.	CMO	1/19/2023	complete an audit for 3 consecutive months with a 95% threshold of compliance. For non-compliance the CNO and A&R Director or its designee will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education. All data gathered will be presented to the quality assurance and performance improvement committee. Documented attestation to the training provided for all providers. Any staff member not completing the education by 1/19/2023 will be removed from the schedule. CMO or its designee will complete an audit for 3

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3. On 12/06/23 at 4:30 PM, an interview with a Discharge Planner (Staff #4) showed that any suicidal ideation identified at discharge is reported to the provider to see what the provider wants to do. Staff #4 stated that discharge can be canceled if a patient presents with suicidal ideation at the time of discharge. 4. On 12/06/23 at 2:00 PM, an interview with an Advanced Registered Nurse Practitioner (ARNP) (Staff #5) showed that suicidal ideation at discharge is not always exclusionary and is determined on a case-by-case basis. Staff #5 stated that the provider looks at family support and any history of chronic suicidal ideation to identify protective factors for suicide risk at discharge. Staff #5 stated that suicide precautions need to be discontinued before the patient can be discharged. 5. Review of the medical record showed that Patient #2 was a 52-year-old man voluntarily admitted on 09/14/22 for suicidal ideation, depression, severe alcohol use, and complicated grief after recently losing his son to suicide. Review of the patient's Master Treatment Plan, dated 09/15/22, showed that the patient should exhibit no suicidal ideation for 48 hours prior to discharge. The area of the Treatment Plan showing that an identified goal was attained, revised, canceled, or continued was blank, and there was no documented resolution of any problems or achievement of any goals prior to discharge. The investigator found no documentation showing the goal was met, revised, or canceled at anytime prior to Patient #2s discharge. A review of Psychiatric Daily Progress Notes showed that the final Psychiatric Daily Progress Note, dated 09/22/22, showed that the patient endorsed suicidal ideation	5. All providers will be reeducated on documenting progress on daily notes with emphasis on treatment planning and documentation of patient with suicidality.			consecutive months with a 95% threshold of compliance. For non-compliance the CNO and A&R Director or its designee will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education. All data gathered will be presented to the quality assurance and performance improvement committee.

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without a plan. The note showed that the treatment plan was for Patient #2 to remain hospitalized for stabilization and a sustainable discharge plan. The provider listed suicide ideation as one of Patient #2's barriers to discharge. Under "Mental Status Exam" within the same note, the provider documented showed that Patient #2 was a suicide risk and was experiencing suicidal ideation. Under the section titled, "Justification for Continued Stay," boxes were checked for continued behavior intolerable to patient or society with high probability of the behavior recurring if the patient were to be discharged. Review of orders and observation sheets showed that on 09/19/22 at 2:00 PM, the provider ordered suicide precautions with Q5 observations. On 09/23/22 at 9:45 AM, Observation sheet documentation showed that the patient was still on suicide precautions with Q5 minute observations. On 09/23/22 at 10:00 AM, Patient #2 was discharged from the facility. The investigator found no evidence showing that the provider discontinued the orders for suicide precautions or Q5 observations before the patient was discharged. 6. On 12/06/23 at 5:25 PM, an interview with the CEO (Staff #7) showed that a patient could be discharged with passive suicidal ideation, and that active suicidal ideation would indicate not having met the discharge criteria. Staff #7 stated that suicide precautions are implemented for patients whose suicidal ideation is active rather than passive. When asked about Patient #2's Treatment Plan goal of being free of suicidal ideation for 48 hours prior to discharge, Staff #7 stated that he was unfamiliar with that being used as a treatment goal and that the Treatment Plan goal was probably amended. Staff #7 stated that if patients are reassessed at discharge as low risk for				

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suicide, they can be released, regardless of the patient's previous suicidal ideation. 7. Upon chart review with the investigator, Staff #7 stated that he did not see any addendum or amendment showing that the goal was met or discontinued. Staff #7 confirmed the investigator's findings that at the time of discharge, Patient #2 was experiencing suicidal ideation, had active orders for suicide precautions with Q5 observations, and did not meet his Treatment Plan goals. Item #2: Access to Firearms 1. Review of the document titled, "Intake Assessment," showed that the patient is asked if they have access to guns or lethal methods at intake. Review of the document titled, "Discharge and Transition Plan," showed that staff asks the patient "are there guns in the home?" and inquires if any guns that may have been in the home have been removed and by whom. 2. Review of policies and procedures showed that the hospital did not have a policy or procedure for discharging voluntary patients with access to guns. 3. On 12/06/23 at 6:00 PM, an interview with the Director of Risk Management (Staff #8) showed that the hospital did not have a defined policy or procedure that guided staff on discharging voluntary patients with access to firearms. Staff #8 stated that the hospital considers it a best practice to ask all patients about firearms at intake, when safety planning, and at discharge. 4. On 12/06/23 at 1:30 PM, an interview with the Director of Assessment and Referral (A&R) (Staff #6) showed that all staff have access to the intake assessment, and that they should resolve any conflicts between the intake and discharge gun access statements				

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with documentation of the removal or withdrawal of access by a friend or family member. She stated that the patient would need to cooperate with safety planning in relation to the possession of or access to a gun in order to be discharged. She stated that they would call the Designated Crisis Responder (DCR) for an assessment for involuntary treatment if a patient did not cooperate with the safety plan related to weapons. 5. On 12/06/23 at 4:30 PM, an interview with a Discharge Planner (Staff #4) showed that she arranges the discharge plan and reports any guns to the Program Therapist and the provider. 6. The investigator reviewed the medical records of 4 patients admitted to the facility between 06/13/22 and 11/07/23. The review showed the following: a. Patient #2 was a 52-year-old man voluntarily admitted on 09/14/22 for suicidal ideation, depression, severe alcohol use, and complicated grief after recently losing his son to suicide. A review of the Intake Assessment, dated 09/14/22, showed that the hospital A&R staff asked the patient if he had access to guns and if there were prior suicide attempts. Intake documentation showed that the patient had access to a gun at his deceased son's house and had attempted suicide multiple times. The Discharge and Transition Plan, dated 09/23/22, showed that the patient was asked if there were guns in the home. The documentation showed that the patient denied having guns in the home. The documentation showed that Patient #2 denied having guns in the home, and staff documented that the patient denied having access to guns. There was no documentation showing that the gun referenced in the intake document was removed or secured.				

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b. Patient #3 was a 43-year-old woman admitted voluntarily on 09/19/22 for Post Traumatic Stress Disorder (PTSD) and depression related to her previous military deployment and combat status. The Intake Assessment, dated 09/19/22, showed that the hospital A&R staff asked the patient if she had access to guns and if she had any history of suicide attempts. The document showed that staff marked "yes" to both questions; in the text boxes to the side of the checkboxes, staff wrote "denies" for both questions. There was no documentation explaining the discrepancy. The Discharge and Transition Plan, dated 09/24/22, showed that Patient #3 denied having guns in the home. There was no documentation showing that staff asked the patient about the discrepancy between the intake document and the discharge document. The Discharge and Transition Plan, dated 09/24/22, showed that the patient denied having guns in the home. No documentation showed that staff asked the patient about the discrepancy between the discharge document and the intake document. 7. On 12/06/23 at 5:25 PM, the investigator interviewed the Chief Executive Officer (Staff #7) about the inconsistencies between the intake and discharge documents. During the interview, Staff #7 stated that the intake question asks about the patient's access to guns or any lethal means, and the discharge question asks specifically about guns in the patient's home. During the interview, Staff #7 confirmed the investigator's findings that the questions were worded differently and stated that he could see how the inconsistency could led to the omission of information about a patient's access to guns outside of the home.				

Submitted by:

NEIL LACANLALE, Ed.D, MAN, PMHNP-BC
Interim Chief Executive Officer
South Sound Behavioral Hospital
Date: 12/28/2023

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

03/05/24

South Sound Behavioral Health
605 Woodland Square Loop SE
Lacey, WA 98503

Re: Complaint 2023-9228

Dear Mr Lacanlale:

I conducted a state hospital licensing complaint investigation at South Sound Behavioral Health onsite 12/04/23-12/06/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 12/28/23.

Hospital staff members sent a Progress Report dated 03/05/24 that indicates all deficiencies have been corrected. The Department of Health accepts South Sound Behavioral Health's attestation that it has corrected all deficiencies cited under WAC 246-322.

We sincerely appreciate you and your staff's cooperation and hard work during the investigation process.

Sincerely,

Mary D'Avanzo, MN/BSN/RN
Nurse Investigator