State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013220	A. BUILDING: _____ B. WING _____	10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals conducted this health and safety survey. The Washington Fire Protection Bureau conducted the fire life safety inspection. Onsite dates: 09/23/19 to 09/27/19 and 09/30/19 to 10/01/19 Examination number: 2019-475 The survey was conducted by: Surveyor #3 Surveyor #4 Surveyor #5 During the course of the survey, surveyors also investigated the following complaints: 2019-1710, 2019-9928, 2019-10496, 2019-10673, 2019-10763, and 2019-10934.	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 PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be returned electronically by November 4, 2019. 4. Return the ORIGINAL REPORT with the required signatures.	
L 210	322-030.3A BACKGROUND-STAFF WAC 246-322-030 Criminal history, disclosure, and background inquiries. (3) The licensee or license applicant shall: (a) Require a Washington state patrol criminal history background inquiry, as specified in RCW 43.43.842	L 210		

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L 210	Continued From page 1 (1), from the Washington state patrol or the department of social and health services for each: (i) Staff person, student, and any other individual currently associated with the hospital having direct contact with vulnerable adults, when engaged on or since July 22, 1989; (ii) Prospective staff person, student, and individual applying for association with the hospital prior to allowing the individual direct contact with vulnerable adults, except as allowed by subsection (4) of this section; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to secure a Washington state patrol criminal history background inquiry for 1 of 20 personnel files reviewed (Staff #409). Failure to obtain a criminal background check for contracted staff that have direct contact with vulnerable adults puts patients at risk of harm from inadequately vetted personnel. Findings included: 1. On 09/26/19 between 8:50 AM and 2:00 PM, Surveyor #4 reviewed personnel files with the Human Resource Manager (Staff #402). The review included the personnel file of a Pharmacy Technician (Staff #409) contracted to work in the hospital's pharmacy and on the patient floor. The document review showed that Staff #409 had not received a Washington state patrol criminal background check prior to working with patients. 2. At the time of the review, Staff #402	L 210		

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L 210	Continued From page 2 acknowledged that the hospital had not followed State law during the hiring process for the contracted employee. .	L 210		
L 315	322-035.1C 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 Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policy and procedure, the hospital failed to develop or implement policies for providing or arranging for the care and treatment of patients, maintaining patient's rights and managing out-of-control behavior including: -Failure to ensure that a Registered Nurse (RN) reassessed patients after a change in condition that required transfer to a higher level of care for 3 of 3 patients reviewed (Patient #517, #519, and #520) (Item #1); -Failure to ensure an RN reassessed a patient with abnormal vital signs consistent with the provider's order for 2 of 2 patients reviewed (Patient #307, #512) (Item #2); -Failure to follow safe medication practice for medication administration (Item #3);	L 315		

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L 315	Continued From page 3 -Failure to ensure staff members completed and documented an initial pain assessment and reassessment after each pain management intervention for 2 of 3 patient records reviewed (Patient #517 and #518) (Item #4); -Failure to ensure nursing staff monitored a patient's glucose and administered insulin consistent with the provider order for 1 of 1 patients reviewed (Patient #526) (Item #5); -Failure to follow hospital policy for emergency medical screening, monitoring and transfer of patients who present themselves to the hospital for care (Item #6); -Failure to place a patient exhibiting "sexually acting out" behaviors on safety precautions, including monitoring, as directed in the hospital's policy (Item #7); -Failure to provide interpretative services for a patient with deafness for 11 of 17 days of involuntary hospitalization (Item #8). Failure to develop and implement policies and procedures for patient care, patient rights and patient safety, risks physical and emotional patient harm, and limits the hospital's ability to provide effective care. Findings included: Item #1- Registered Nurse Assessment 1. Document review of the hospital's policy titled, "Admission Process Inpatient," policy number 5127934, approved 10/18, showed that a Registered Nurse would complete the admission	L 315		

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L 315	Continued From page 4 nursing assessment within 8 hours of admission. 2. On 09/23/19 at 12:54 PM, Surveyor #5 and a Registered Nurse (Staff #512) reviewed the medical record for Patient #517 who transferred from the hospital's Detoxification Unit to the Inpatient Mental Wellness Unit for the treatment of Suicidal Ideation. Upon discharge from the Detoxification Unit, the patient became suicidal and transferred to the Mental Wellness Unit. Surveyor #5 found no evidence that a Registered Nurse completed an admission assessment related to the change in the patient's status. 3. On 09/23/19 at 2:46 PM, Surveyor #5 asked the nurse about reassessment for a change in a patient's medical or mental health condition that requires transfer to another unit or higher level of care. Staff #512 stated that nursing does not reassess the patients when they transfer from the Sober Living Unit, following detoxification from Drugs or Alcohol. 4. On 09/23/19 at 3:00 PM, Surveyor #5 requested hospital policies related to nursing reassessment after change in condition or transfer. Surveyor #5 received a policy titled, "Program Overview/Scope of Care," policy number 5441050, approved 07/19, a policy titled, "Admission Process Inpatient," policy number 5127934, approved 10/18, and a policy titled "Shift Nursing Assessment/Reassessment," policy number 6219317, approved 07/19. The policies did not address assessment by a nurse when patients transferred to a higher level of care or patients experienced a substantial change in medical or mental health condition. 5. On 09/26/19 at 12:00 PM, Surveyor #5 and the Chief Nursing Officer (Staff #506), reviewed the	L 315		

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L 315	Continued From page 5 medical record for Patient #519 for the 09/03/19 admission for the treatment of Heroin Detoxification. On 09/10/19, the patient transferred to the Inpatient Mental Health Unit for increased depression and suicidal ideation. Surveyor #5 found no evidence a Registered Nurse completed an assessment of the patient upon admission to the Inpatient Mental Health Unit related to the change in the patient's status. 6. On 09/26/19 at 12:50 PM, a Licensed Clinical Social Worker (Staff #520) stated that when a patient transfers from the substance abuse unit to the mental health unit, a therapist reassesses them. Staff #520 confirmed that the medical record did not show a nursing reassessment, or any documentation in a nursing progress note that showed the patient transferred to the mental health unit for suicidal ideation. 7. On 09/26/19, Surveyor #5 reviewed the medical record for Patient #523 who was admitted to the Detox Unit 01/10/19 and transferred to the Mental Wellness Unit 01/18/19 for symptoms of Suicidal Ideation. Surveyor #5 found no evidence that nursing staff reassessed the patient related to the patient's change in condition. Item #2- Abnormal Vital Signs 1. Document review of the hospital's Vital Signs Flow sheet, document number IP-FSW-101-06, updated 01/15/16, showed that a Registered Nurse (RN) is to review patient blood pressures below 90 mm Hg systolic and below 60 mm Hg diastolic. Document review of the hospital's Alcohol and/or	L 315		

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L 315	Continued From page 6 Benzodiazepine CIWA Symptom Triggered Detox Protocol, document number IP-POW-062-03, updated 03/29/17, showed that staff are to measure vital signs every six hours. If the systolic blood pressure is greater than 180 mm Hg and or diastolic blood pressure greater than 120 mm Hg, staff should contact the licensed independent practitioner. 2. On 09/25/19 at 9:20 AM, Surveyor #3 reviewed the medical record of Patient #307 who was admitted on 08/05/19 for alcohol dependence. The Clinical Institute Withdrawal Assessment (CIWA) sheet showed: a. On 08/06/19 at 06:00 AM, the patient's blood pressure was 181/116 mm Hg. b. Although CIWA scores were assessed at 09:00 AM and 12:30 PM, the patient's record showed no documented vital sign measurements despite a Registered Nurse's initials at those times indicating they performed the CIWA assessment. c. On 08/06/19 at 6:00 PM, the patient's blood pressure was 170/90 mm Hg. 3. Surveyor #3 found no evidence in the medical record to indicate the Registered Nurse had contacted the provider as required by the standing protocol for elevated blood pressure obtained at 6:00 AM. Further, the surveyor found no evidence that the clinical staff checked or rechecked blood pressure for a period of twelve hours despite the order for vital sign measurements every six hours. 4. On 09/26/19, Surveyor #5 and the Chief Nursing Officer (Staff #506) reviewed the medical record for Patient #520 who was admitted on	L 315		

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L 315	Continued From page 7 09/03/19 for Unspecified Schizophrenia. The review showed that on 09/03/19, a provider wrote an order for daily vital signs. The vital signs flow sheet showed: a. On 09/12/19, the patient's blood pressure was 101/49 mm/hg b. 09/18/19, the patient's blood pressure was 91/57 mm/hg c. On 09/21/19, the patient's morning blood pressures were below parameters identified on the hospital document. The column of the document titled "RN Signature" was blank. Surveyor #5 found no evidence an RN reviewed the abnormal vital signs. 5. At the time of the review, Staff #506 confirmed the finding and stated that the nurse should review the vital signs when they fall out of parameter. 6. On 09/26/19, Surveyor #5 reviewed the medical record for Patient #524. The review showed that on 01/25/19 the patient's blood pressure was 97/57 mm/hg. Surveyor #5 found no evidence that an RN reviewed the abnormal vital signs. Item #3- Pre-pouring of Medications 1. Document review of the hospital's policy and procedure titled, "Medication Administration -General Guidelines," PolicyStat ID #4985266, approved 10/18, showed that prior to administration, the medication and dosage schedule on the patient's medication administration record is compared with the medication label.	L 315		

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L 315	Continued From page 8 2. On 09/26/19 at 8:45 AM, Surveyor #3 observed a Registered Nurse (Staff #303) open a cabinet door in the medication room and retrieve a white basket with four patient-labeled cups containing medications. The observation showed that two of the patient-labeled cups had some medications out of their original packaging. 3. At the time of the observation, Surveyor #3 interviewed the Registered Nurse (Staff #303) about the observation. Staff #303 stated that she had to prepare the medications ahead of time and then provide them to the patients. She stated that this was her practice. 4. On 09/26/19 between 8:45 AM and 09:00 AM, Surveyor #3 interviewed the Director of Nursing (Staff #301) about the observation. Staff #301 stated that it was not their policy to pre-pour medications or remove medications out of their packaging prior to administration. Item #4- Pain Medication Assessment and Reassessment 1. Document review of the hospital's policy titled, "Medication Administration-General Guidelines," policy number 4985266, approved on 10/18, showed that when a patient receives an "As Needed" (PRN) medication for complaints of pain, the clinical staff must re-evaluate the patient's pain and rate it as 1-10 for effectiveness within an hour of the PRN medication administration. 2. On 09/23/19 at 12:54 PM, Surveyor # 5 and a Registered Nurse (Staff #512) reviewed the medical record for Patient #517. The patient had a history of chronic low back pain and lower	L 315		

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L 315	Continued From page 9 extremity muscle cramps. The patient utilized a wheelchair for mobility. The review showed: a. On 08/30/19 at 6:35 PM, nursing staff administered Ibuprofen 600 mg by mouth. Surveyor #5 found no evidence nursing staff reassessed the patient after administering the PRN medication. 3. On 09/25/19 at 10:17 AM, Surveyor #5 and Corporate Quality Director (Staff #509), reviewed the medical record for Patient #518 who was admitted on 08/22/19 for the treatment of Unspecified Psychosis. The patient had a history of Schizophrenia, Paranoid Depression, and Type II Diabetes Mellitus. The review showed: a. On 09/14/19 at 10:43 PM, nursing staff administered Ibuprofen 600 mg by mouth. Surveyor #5 found no evidence nursing staff assessed an initial pain score or reassessed the patient after administering the PRN medication. b. On 09/14/19 at 9:10 PM, nursing staff administered Ibuprofen 600 mg by mouth. Surveyor #5 found no evidence nursing staff assessed an initial pain score or reassessed the patient after administering the PRN medication. 4. At the time of the observation, Staff #509 confirmed that staff had not documented and initial pain score or reassessed the patient after admiistering the PRN medications. Item #5- Insulin Coverage for High Blood Glucose Levels 1. On 09/25/19 at 10:17 AM, Surveyor #5 and the	L 315		

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L 315	Continued From page 10 Corporate Quality Director (Staff #509) reviewed the medical record for Patient #518 who was admitted on 08/22/19 for the treatment of Unspecified Psychosis. The patient had a history of Schizophrenia, Paranoid Depression, and Type II Diabetes Mellitus. The review showed the following: a. On 08/23/19, a provider ordered blood sugars prior to every meal and at bedtime. The provider ordered Low dose Sliding Scale Correctional Insulin Protocol with no nighttime insulin coverage. The protocol showed that for a blood glucose level between 110 mg/dl and 150 mg/dl nursing staff were to administer 1 unit of Lispro insulin subcutaneously. b. On 09/26/19 at 5:00 PM, Surveyor #5 found no evidence staff monitored the patient's blood glucose level or that the patient received coverage. c. On 09/10/19 at 12:00 PM, the patient's blood sugar was 140 mg/dl. The provider order showed nursing staff should have administered 1 unit of Lispro insulin subcutaneously. Surveyor #5 found no evidence the patient received the insulin. d. On 09/12/19 at 7:00 AM, the patient's blood sugar was 120 mg/dl. The provider order showed nursing staff should have administered 1 unit of Lispro insulin subcutaneously. Surveyor #5 found no evidence the patient received the insulin. e. On 09/12/19 at 12:00 PM, the patient's blood sugar was 115 mg/dl. The provider order showed nursing staff should have administered 1 unit of Lispro insulin subcutaneously. Surveyor #5 found no evidence the patient received the insulin.	L 315		

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L 315	Continued From page 11 2. At the time of the review, Staff #509 confirmed that staff did not document the patietn received insulin for elevated blood sugars . Item #6- Assessment and Transfer 1. Document review of the hospital's policy titled, "Emergency Medical Treatment and Active labor Act (EMTALA)," policy number 6229033, approved 07/19, showed that all persons presenting to the hospital will receive a medical screening examination to determine if they have an emergency medical condition including a psychiatric emergency. The chart should document continued monitoring until the patient is stabilized or transferred. When a patient transfers to another medical facility, staff are to call an emergency department able to provide appropriate care, and discuss the transfer with the patient. If the patient consents, call emergency medical services, and complete and send a copy of the EMTALA Physicians Assessment and Certification to transfer form to the receiving hospital. If the patient refuses to be transferred and is not at imminent risk, complete a copy of the EMTALA Physician Assessment and Certification Consent to transfer, noting the patient's refusal and complete the assessment process. 2. On 10/01/19 at 11:00 AM, Surveyor #5 reviewed screening documents for Patient #513 who presented 3 times in 24 hours for a psychiatric crisis and treatment for psychosis: On 01/04/19 at 7:04 AM, on 01/04/19 at 7:30 PM and on 01/05/19 at 12:05 AM. The review showed: a. On 01/04/19 at 7:04 AM, The EMTALA log showed the patient was "Deflected."	L 315		

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L 315	Continued From page 12 b. On 01/04/19 at 7:40 AM, the completed Safety Assessment Form showed the patient was hearing voices telling him to harm others and was having current thoughts of harming himself "to a certain extent." c. Review of the form showed the Screening Assessment was incomplete past page 4 as the patient was unable to stay awake. The section of the document titled "Clinician Assessment" stated that the patient might meet criteria for inpatient or outpatient care. Staff failed to complete the remainder of the clinician assessment. d. The Personalized Treatment Recommendation completed by a Licensed Mental Health Counselor (Staff # 515) showed that the staff member recommended that the patient go home, sleep, and return later in the day to complete the assessment. Surveyor #5 found no evidence that staff consulted a provider or informed them of the patient's condition as required by hospital policy. Surveyor #5 found no evidence that a Registered Nurse assessed the patient prior to sending them home. e. On 01/04/19 at 6:02 PM, the EMTALA log showed that staff referred the patient to an Emergency Room for further evaluation. f. On 01/04/19 at 6:20 PM, the completed Safety Assessment Form showed the patient was having current thoughts of harming himself and the patient stated, "I want to die." g. Document review of the Screening Assessment showed "The patient returns from a previous deflection due to patient being so sleepy	L 315		

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L 315	Continued From page 13 he could not engage in answering questions ...patient endorses suicide ideation with no plans or intent, upon return this young man is still lethargic, with difficulty keeping his eyes open, unable to articulate answers." Documentation in the section of the form titled "Clinician Assessment" showed "Patient is unable to complete assessment for 2nd time due to lethargy." The Screening Assessment was incomplete. h. Document review of the Personalized Treatment Recommendation showed that the provider requested the patient to seek medical evaluation at an Emergency Room for clearance. Surveyor #5 found no evidence staff discussed a transfer option with the patient or completed the EMTALA Physicians Assessment and Certification to transfer form. i. Surveyor #5 reviewed the Emergency Room notes for 01/04/19 that showed the patient's mother transported the patient to the Emergency Department. j. On 01/05/19 at 12:05 AM, the EMTALA log showed the patient was admitted to inpatient care for the treatment of a psychiatric condition. 3. On 10/01/19 at 12:00 PM, the Interim Quality Director (Staff #508) confirmed the finding and stated that staff should have completed a transfer form and placed a copy in the patient's record. She stated that the intake department now has Registered Nurses and that there are Nursing Supervisors available to provide nursing assessments for medical concerns 4. On 10/01/19 at 12:00 PM, Surveyor #5 and the	L 315		

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L 315	Continued From page 14 Interim Quality Director (Staff #508) reviewed the medical records for 3 patients (#514, #515, and #516) who presented to the hospital for emergency psychiatric conditions and received referrals to another facility. The review showed: a. On 06/24/19 at 10:56 AM, Patient #514 presented for Alcohol Detoxification. Documentation in the EMTALA log showed that the "Patient blood alcohol too high, to return with support for treatment." The patient's medical record showed he had a blood alcohol level of .401. Surveyor #5 found no evidence the patient received a medical screening; no evidence staff discussed transfer options with the patient or that staff completed the EMTALA Physicians Assessment and Certification to transfer form. There was no documentation of a safe discharge. b. On 06/30/19 at 2:51 PM, Patient #515 presented to the hospital. The EMTALA log showed that staff sent the patient to an Emergency Department. Surveyor #5 found no evidence the patient received a medical screening; no evidence staff discussed transfer options with the patient or that staff completed the EMTALA Physicians Assessment and Certification to transfer form as directed by hospital policy. On 06/30/19 at 11:53 PM, the EMTALA log showed a second entry for Patient #515 that documented the patient's inpatient admission and showed the patient was admitted for "Suicidal Ideation with a Specific Plan." c. On 06/25/19 at 12:28 PM, Patient #516 presented to the hospital. The EMTALA log showed the patient was to return in the afternoon/evening of 06/29/19 for detoxification.	L 315		

State of Washington

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L 315	Continued From page 15 Staff #508 was unable to locate any documentation for this patient's presentation for emergency care. Surveyor #5 found no evidence the patient received a medical screening, no evidence staff discussed transfer options with the patient, or that staff completed the EMTALA Physicians Assessment and Certification to transfer form as directed by hospital policy. Surveyor #5 also found no evidence the patient was safely discharged. 3. At the time of the review, Staff #508 confirmed the findings and stated that she had provided "just in time" education for the staff in triage, regarding documentation requirements. Item #7- Safety Precautions 1. Document review of the hospital's policy titled, "Sexual Acting Out (SAO)," policy number 6005832, approved 02/19, showed that sexual behaviors of any kind are prohibited by the facility. Reports of sexual acting out between patients will be investigated. All allegations of observations of sexual behavior will be investigated by the facility. Patients with alleged or observed sexual acting out behaviors will be assessed daily by the physician to ensure appropriate levels of care. Staff will obtain an order for SAO precautions and the Registered Nurse will note SAO precautions on the daily Shift Nursing Assessment Form. The RN addresses the patient's status, SAO precautions, and level of observation in daily treatment teams and documents in the Nursing Assessment every 24 hours. A physician order is required to decrease or discontinue SAO precautions. An incident report will be filed.	L 315		

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L 315	Continued From page 16 2. On 09/23/19 at 12:54 PM, Surveyor #5, a Registered Nurse (Staff #512), and the Director of Ancillary and Outpatient Services (Staff #516) reviewed the medical record for Patient #517. The review showed that on 09/21/19, the patient engaged in an occurrence of Sexually Acting Out (SAO) behavior with a roommate and the roommate was moved to a different room. Surveyor #5 found no evidence staff placed Patient #517 on SAO precautions. Surveyor #5 also found no evidence a provider assessed the patient consistent with the hospital's policy. 3. At the time of the review, Staff #512 stated that she did not know if the hospital had SAO precautions. Staff #512 showed the surveyor an admission document, which showed different types of precautions. The document did not list SAO precautions as an option. Staff #512 stated that staff would not file an incident report unless there was patient harm. Staff #516 stated that the hospital did have a policy on SAO. 4. On 09/25/19 (two days later), Surveyor #5 completed the medical record review of Patient #517. The review showed staff had not yet placed the patient on SAO precautions. Item #8- Interpretive Services 1. Document review of the hospital's policy titled, "Communication with Persons with Limited English Proficiency (LEP) and Sensory Disabilities," policy number 5182826, approved 09/18, showed that the hospital will promptly identify the language and communication needs of the LEP person. The hospital will obtain an outside interpreter, use a staff member who is qualified to interpret, or use a language services	L 315		

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L 315	Continued From page 17 line. In the event that a patient requires a scope of service beyond the hospital capabilities, the hospital will provide referral to the needed service and support in the coordination of care. 2. On 09/27/19, Surveyor #5 reviewed the medical record for Patient #512 who was admitted involuntarily on 07/26/19 for the treatment of psychosis and violent behavior. The patient was discharged on 08/12/19. The record review showed: a. A History and Physical completed on 07/26/19 at 7:55 PM showed that the patient was deaf and communicating with the provider by hand signals, reading the provider's lips, and some sounds. b. The Psychosocial Assessment completed on 07/27/19 at 1:00 PM showed that the patient was deaf and needed an interpreter. c. The Comprehensive Psychiatric evaluation completed on 07/27/19 at 2:00 PM showed the patient is deaf and did not speak. On 07/28/19, a day shift nursing assessment showed that "there was no interpreter on the unit at this time to facilitate communication." d. A psychiatric progress note on 07/29/19 showed the patient is "mute" and there was an interpreter present. e. An inpatient therapy note dated 08/03/19 at 5:11 PM, showed the patient did not attend group and was unavailable for treatment as no interpreter was present. f. On 08/03/19, a psychiatric progress note stated that an interpreter could not be located and the	L 315		

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L 315	Continued From page 18 day shift nursing assessment stated that the patient communicated with the nurse on paper. f. On 08/04/19, a psychiatric progress note stated that an interpreter could not be located. g. On 08/05/19, a psychiatric progress note stated that the patient was easily frustrated which may be due to his language deficit. The provider stated, "Thought content unable to be assessed fully as interpreter is not present again at this session." On 08/06/19, a night shift nursing assessment showed that the nurse was unable to complete the shift assessment related to the communication barrier and due to a sign language barrier. h. O 08/07/19, a psychiatric progress note stated that an interpreter could not be located. On 08/08/19, a night shift nursing assessment stated, "Patient is deaf and as a result very little communication." h. On 08/10/19, a psychiatric inpatient progress note showed that there was no interpreter present for the evaluation and that staff communicated with the patient via notes. The provider was unable to assess orientation and thought processes. i. On 08/11/19, a psychiatric inpatient progress note showed that there was not an interpreter available, but a staff member with knowledge of ASL (American Sign Language) interpreted for the patient. On 08/11/19, a day shift nursing assessment	L 315		

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L 315	Continued From page 19 stated, "Patient is deaf and hard to communicate needs or interact with others." "Patient is deaf but no interpreter available." On 08/11/19, a night shift nursing assessment stated, "Communicated with nurse through writing." 3. On 09/27/19 at 11:00 AM, the Chief Nursing Officer (Staff #506) verified the observation and stated that the hospital had trouble getting an American Sign Language (ASL) interpreter to come to the facility and were only able to provide an interpreter for 3 days. .	L 315		
L 320	322-035.1D POLICIES-PATIENT RIGHTS 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: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Based on document review, interview, and review of hospital policy and procedures, the hospital failed to follow its procedure for provision of written response to complainants for filed grievances for 1 of 4 grievances reviewed (Patient #305). Failure to provide written notice of the outcome of	L 320		

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L 320	Continued From page 20 the grievance investigation and steps taken on behalf of the patient to investigate the grievance violates their right to be informed about how the hospital investigated and resolved the grievance. Findings included: 1. Document review of the hospital policy and procedure titled, "General Grievances and Patient Advocacy (IP, PHP & IOP), " PolicyStatID # 6451484, last revised 09/19, showed that when the complaint issue has been resolved, the patient will receive written notification of the results within 15 business days. The Patient Advocate will respond in writing to the complainant and address the following areas: (1) The name of the Hospital contact (2) The steps taken on behalf of the individual to investigate the complaint (3) The results of the process (4) The date of completion of the complaint process (5) The steps to take if dissatisfied with the outcome 2. On 09/27/19 at 11:25 AM, Surveyor #3 reviewed the hospital's grievance log. The review showed that on 05/29/19, Patient #305 filed a grievance with the hospital concerning the quality of care with an outpatient program. On 06/29/19, the patient sent a follow-up letter with additional information about her concerns. The grievance log showed that the hospital sent a letter to the complainant summarizing a conversation with the Director of Assessment (Staff #306). The "notes column" showed that resolution was done verbally and that a date was needed when the letter was sent. In the grievance file, the surveyor reviewed a copy of an undated and unsigned letter from the	L 320		

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L 320	Continued From page 21 hospital indicating resolution of Patient #305's grievance. The letter did not include information on steps the complainant could take if dissatisfied with the outcome. 3. At the time of review, Surveyor #3 asked the Director of Nursing (Staff #301) if she knew when the hospital sent the letter to the complainant. Staff #301 stated that she could not determine when the hospital sent the letter. She indicated that the hospital had recent turnover of staff responsible for handling complaints. .	L 320		
L 360	322-035.1L POLICIES-SMOKING 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: (l) Smoking on the hospital premises; This Washington Administrative Code is not met as evidenced by: . Based on observation and document review, the hospital failed to implement their facility smoking policy consistent with Revised Code of Washington (RCW) 70.160, which addresses smoking in public places. Failure to prohibit smoking consistent with state law puts patients, staff and visitors at risk of harm from exposure to second-hand smoke. Findings included: 1. Document review of the hospital policy titled,	L 360		

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L 360	Continued From page 22 "Hospital Smoking Policy", last revised 07/19, showed that all smoking areas will be located appropriately to prevent re-circulation of smoke into the facility. The policy also showed a reference to RCW 70.160.075, which prohibits smoking within 25 feet of entrances, exits, windows that open, and ventilation intakes. 2. On 09/23/19 at 10:30 AM, Surveyor #4 observed signs adjacent to the hospital's outside parking area. The observation showed that the signs indicated smoking was prohibited within 20 feet of the building, which is not compliant with hospital policy or state law. .	L 360		
L 435	322-040.4 ADMIN-ADMINISTRATOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (4) Appoint an administrator responsible for implementing the policies adopted by the governing body; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of hospital documents, the hospital's Governing Body failed to appoint an administrator to be responsible for implementing the policies adopted by the Governing Body and be accountable for all aspects of patient care. Failure to have an administrator to direct and oversee all aspects of hospital treatment and policy implementation, puts patients at risk of harm from substandard care.	L 435		

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L 435	Continued From page 23 1. On 10/01/19 at 11:10 AM, Surveyor #5, Surveyor #4, and Surveyor #3 interviewed available members of the hospital's Governing Body (both present and attending via teleconference). Members included the hospital's Chief Executive Officer (Staff #412) and 3 members of the hospital's parent corporation: the Medical Director (Staff #413), The Chief Operating Officer (Staff #414) and the Vice President of Nursing (Staff #415). The surveyors also reviewed the Governing Body meeting minutes. Review of the Governing Body meeting minutes showed no evidence the Governing Body had documented approval for the appointment of the current administrator. 2. On 10/01/19 at 11:10 AM, the surveyors asked the members of the Governing Body (both present and attending via teleconference) if there were meeting minutes to document the appointment of the Current Chief Executive Officer (Staff #412) as administrator for the hospital. After the conclusion of the Governing Body meeting, Staff #412 produced a 1- page document titled,"Minutes of Special Meeting of the Governing Board of Rainier Springs, LLC," dated 10/01/19. The document indicated that two members of the hospital's Governing Board (The parent company's Chief Operating Officer and Chief Medical Officer) held a special meeting via telephone, that resulted in nomination and appointment of Staff #412 as the hospital's administrator.	L 435		
L 495	322-040.8i ADMIN RULES-PERFORM EVALS WAC 246-322-040 Governing Body and	L 495		

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L 495	Continued From page 24 Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (i) Mechanisms to monitor and evaluate quality of care and clinical performance; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of the hospital's Governing Body Bylaws and Performance Improvement Plan, the hospital's Governing Body failed to implement and maintain mechanisms to monitor and evaluate quality of care and clinical performance including: - Failure to implement the quality assessment and performance improvement (QAPI) plan (Item #1); - Failure to aggregate and analyze data regarding patient medication errors, patient injuries, and other adverse events for patterns, trends and common factors through the hospital's quality program (Item #2); - Failure to ensure the hospital developed and implemented performance improvement activities and action plans for activities not meeting minimum thresholds, that supported hospital quality indicators related to patient safety and quality of care (Item #3); -Failure to ensure that the program reflected the complexity of the hospital's organization and services, and involved all hospital departments including those services furnished under contract (Item #4). Failure to have a fully integrated Quality Program	L 495		

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L 495	Continued From page 25 that encompasses all areas of the hospital, collects and analyzes data on processes and events that affect patient care and develops action plans to improve identified problems, puts patients at risk of harm from substandard care. Findings included: Item #1- Governing Body Oversight 1. Document review of the hospital's quality document titled, "Organizational Quality Improvement Plan," policy number 6366314, approved 07/19, showed that the hospital's Organizational Quality Improvement plan is to ensure the Governing Board, medical staff, and professional service staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. The Governing Board is responsible for the quality of care provided. The Governing Board has a responsibility to evaluate the effectiveness of the quality improvement activities performed throughout the hospital and the organizational quality improvement program as a whole. The Governing Board requires a detail and frequency of data collection for all indicators and performance processes outline in the Quality Plan including reporting of all patient care and service indicators to the Patient Safety Committee on a monthly basis. Document review of the hospital's policy titled, "Governing bylaws," policy number 6313788, approved 07/19, showed that the Governing Body has the ultimate responsibility for performance improvement, risk management, and outcomes. The Governing Board oversees performance functions through its appointment and	L 495		

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L 495	Continued From page 26 reappointment responsibilities, receiving and acting on reports that summarize activities of performance improvement, risk management, safety, human resources, budget, and other hospital based functions. Document review of the hospital document titled, "Hospital Medical Staff Bylaws," (last approved 11/18), showed that responsibilities for medical staff and providers with clinical privileges include continuous quality improvement, professional practice evaluation, peer review, utilization review, quality evaluation and related monitoring activities as required. 2. On 09/30/19 at 2:50 PM, Surveyor #5, Surveyor #4, the Chief Nursing Officer (Staff #506) and the Interim Director of Quality (Staff #508) reviewed the hospital's Quality Improvement Program. The review showed: a. Hospital staff did not report data for quality indicators identified in the Hospital's Quality Plan to the Quality Committee. b. There was line item data for medication-missed doses, discharge summaries, and contraband reported in the meeting minutes. c. The data reported for January, February, March, April, May, June, July, and August 2019 showed the hospital did not meet goals established by the Quality Committee for medication missed doses, discharge summaries, and contraband. There was no evidence that the Quality Committee developed, reported, or tracked Process Improvement Plans for indicators not meeting their benchmarks. d. Surveyor #5 found no evidence that the	L 495		

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L 495	Continued From page 27	L 495		

hospital integrated Clinical Laboratory Services, Nutritional Services, Pharmacy and Therapeutic Services, Discharge Planning or Infection Control into the Quality Improvement Program.

3. On 10/01/19 at 11:10 AM, Surveyor #5, Surveyor #4, and Surveyor #3 interviewed the hospital's Governing Body and reviewed the Governing Body meeting minutes. Review of the Governing Body meeting minutes showed no evidence the Governing Body ensured that the hospital tracked, or analyzed all quality assessment and performance improvement quality indicators identified in the hospital's Quality Improvement Plan. The review also showed no evidence that the hospital developed process improvement activities to address the 3 indicators (medication missed doses, contraband, and Discharge Summaries) that showed consistent non-compliance with the hospital's established goals.

At the time of the interview, the Springstone Sr. Vice-President of Operations (Staff #517) stated that the Governing Body reviewed a scorecard maintained by the hospital. Staff #517 also stated that when the Governing Board finds that the hospital is "falling short" they take action by using "platform" staff to work with hospital staff to meet expectations or make staff changes, adding that this was not necessarily something that would be found in the minutes.

4. Surveyor #5 asked the Governing Body about its involvement in quality tracking, monitoring, and process improvement for the hospital's pharmacy services, based on the issues identified during the investigation. The Springstone Vice President of Nursing (Staff #518) stated that they have "a lot of interaction with the pharmacist and

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L 495	Continued From page 28 complete an annual review," and that they (the parent company) did not "see issues across the platform." Item #2- Data Aggregation and Analysis 1. Document review of the hospital's document titled, "Organizational Quality Improvement Plan," policy number 6366314, approved 07/19, showed that the hospital's Organizational Quality Improvement plan is to ensure the Governing Board, medical staff, and professional service staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. As a patient is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines establishing the plans, processes, and mechanisms that comprise the performance improvement of the hospital. The program consists of focus components including quality improvement, patient safety, and quality assessment, and quality control activities. The status of identified problems and action plans is tracked to assure improvement or problem resolution. The scope of the organizational quality improvement program includes performance monitoring, assessment, and evaluation of all individuals with clinical privileges. The continuous quality improvement activities of the medical staff and all appropriate departments and services and disciplines that affect patient care and safety and medical staff services within the medical staff service committee will be reviewed including: a. Medication Management b. Pharmacy and Therapeutics Function c. Safety Management	L 495		

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L 495	Continued From page 29 d. Risk Management e. Infection Control f. Utilization Management Patient Care and Quality Control Activities are monitored, assessed, and evaluated including: a. Clinical Laboratory Services b. Nursing Services c. Nutritional Services d. Pharmacy Services e. Therapeutic and Discharge Planning A Patient Safety Committee will operate as an independent committee dedicated to implementation and monitoring of the effectiveness of the Patient Safety Program and will report committee findings, determinations, and actions to the Quality Improvement Committee. Information reporting will contain concurrent data related to ongoing patient safety and medical error issues and well as information related to the proactive risk assessment. Undesirable patterns or trends in performance are analyzed for performance measures related to: a. Management of hazardous conditions b. Medication management c. Restraint use and seclusion use d. Behavior management and treatment e. Appropriateness of pain management f. Care, treatment or services to high-risk populations	L 495		

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L 495	Continued From page 30 g. National patient safety goals. In-depth analysis is conducted for levels of performance, patterns, or trends for: a. All serious adverse drug events b. All significant medication errors c. Hazardous conditions Data on all action plans will be collected and reported to the Quality/Safety Committee on a monthly basis. Results of outcomes of quality improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service committees, ancillary, nursing, Safety Committees, and the Continuous Quality Improvement team will be reported to Quality Improvement Committee on a monthly/bimonthly or quarterly bases as designated by the committee. 2. On 09/30/19 at 2:50 PM, Surveyor #5, Surveyor #4, the Chief Nursing Officer (Staff #506) and the Interim Director of Quality (Staff #508) reviewed the hospital's Quality Improvement Program. Surveyor #5 observed that data for quality indicators identified in the Hospital's Quality Plan were not reported to the Quality Committee. Surveyor #5 observed only line item data for medication-missed doses, discharge summaries, and contraband reported in the meeting minutes. Surveyor #5 found no evidence of analysis of the line-itemed data. 3. On 09/30/19 at 2:50 PM, Surveyor #5, Surveyor #4, the Chief Nursing Officer (Staff	L 495		

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L 495	Continued From page 31 #506) and the Interim Director of Quality (Staff #508) reviewed the hospital's Quality Improvement Program. Surveyor #5 found no evidence that quality staff measured, analyzed, or tracked patient safety activities identified in the hospital's quality Improvement Plan to demonstrate measurable improvement in indicators. 4. At the time of the review, Staff #506 and #508 confirmed the finding and stated that medication missed doses, discharge summaries, and contraband were the indicators reported as part of the parent corporation's quality metrics and that the hospital did track other quality measures that were not reported to the Quality Committee. Staff #506 stated that there could be improvement in meeting minutes to capture information shared in the committee. Item #3- Action Plans and Processes for Hospital-Wide Quality Improvement 1. Document review of the hospital's document titled, "Organizational Quality Improvement Plan," policy number 6366314, approved 07/19, showed that the program consists of focus components including quality improvement, patient safety, and quality assessment, and quality control activities. The hospital tracks the status of identified problems and action plans to assure improvement or problem resolution. Data on all action plans will be collected and reported to the Quality/Safety Committee on a monthly basis. Results of outcomes of quality improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service committees, ancillary, nursing, Safety	L 495		

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L 495	Continued From page 32 Committees, and the Continuous Quality Improvement team will be reported to Quality Improvement Committee on a monthly/bimonthly or quarterly bases as designated by the committee. 2. On 09/30/19 at 2:50 PM, Surveyor #5, Surveyor #4, the Chief Nursing Officer (Staff #506) and the Interim Director of Quality (Staff #508) reviewed the hospital's Quality Improvement Program. The review showed: a. Hospital staff did not report data for quality indicators identified in the Hospital's Quality Plan to the Quality Committee. b. There was line item data for medication-missed doses, discharge summaries, and contraband reported in the meeting minutes. The data reported for January, February, March, April, May, June, July, and August 2019 showed the hospital did not meet goals established by the Quality Committee for medication missed doses, discharge summaries, and contraband. There was no evidence that the Quality Committee developed, reported, or tracked Process Improvement Plans for indicators not meeting their goals. c. Surveyor #5 found no evidence the hospital integrated Clinical Laboratory Services, Nutritional Services, Pharmacy and Therapeutic Services, Discharge Planning or Infection Control into the Quality Improvement Program. 3. At the time of the review, Staff #506 confirmed the finding and stated that the hospital had workgroups addressing the issues but that the information was not reported in the Quality Committee. The staff member also stated that the	L 495		

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L 495	Continued From page 33 hospital could improve the meeting minutes to capture information that was shared in the committee. Item #4- Complexity of Services 1. Document review of the hospital's quality document titled, "Organizational Quality Improvement Plan," policy number 6366314, approved 07/19, showed the scope of the organizational quality improvement program includes performance monitoring, assessment, and evaluation of all individuals with clinical privileges. The continuous quality improvement activities of the medical staff and all appropriate departments and services and disciplines that impact patient care and safety and medical staff services within the medical staff service committee will be reviewed including: a. Medication Management b. Pharmacy and Therapeutics Function c. Safety Management d. Risk Management e. Infection Control f. Utilization Management Patient Care and Quality Control Activities are monitored, assessed, and evaluated including: a. Clinical Laboratory Services b. Nursing Services c. Nutritional Services d. Pharmacy Services e. Therapeutic and Discharge Planning A Patient Safety Committees will operate as an independent committee dedicated to implementation and monitoring of the effectiveness of the Patient Safety Program and	L 495		

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L 495	Continued From page 34 will report committee findings, determinations, and actions to the Quality Improvement Committee. Information reporting will contain concurrent data related to ongoing patient safety and medical error issues and well as information related to the proactive risk assessment. Undesirable patterns or trends in performance are analyzed for performance measures related to: a. Management of hazardous conditions b. Medication management c. Restraint use and seclusion use d. Behavior management and treatment e. Appropriateness of pain management f. Care, treatment or services to high-risk populations g. National patient safety goals. In-depth analysis is conducted for levels of performance, patterns, or trends for: a. All serious adverse drug events b. All significant medication errors c. Hazardous conditions Data on all action plans will be collected and reported to the Quality/Safety Committee on a monthly basis. Results of outcomes of quality improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service committees, ancillary, nursing, Safety Committees, and the Continuous Quality Improvement team will be reported to Quality Improvement Committee on a monthly/bimonthly or quarterly bases as designated by the committee.	L 495		

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L 495	Continued From page 35 2. On 09/30/19 at 2:50 PM, Surveyor #5, Surveyor #4, the Chief Nursing Officer (Staff #506) and the Interim Director of Quality (Staff #508) reviewed the hospital's Quality Improvement Plan and Program. Surveyor #5 observed that the hospital's Quality Plan listed indicators for Patient Care and Quality Control Activities as "Services" for example, "Pharmacy Services" or by management such as "Safety Management" but did not identify the specific quality indicators to be measured within that service or program management. Surveyor #5 observed only line item data for medication-missed doses, discharge summaries, and contraband reported in the meeting minutes, which did not reflect the complexities of services provided by the hospital. 3. At the time of the review, Staff #506 and #508 confirmed the finding and stated that medication missed doses, discharge summaries, and contraband were the indicators the hospital reported as part of their parent company's quality metrics and that the hospital did track other quality measures that were not reported to the Quality Committee. Staff #506 also stated that there could be improvement in meeting minutes to capture information shared in the committee. .	L 495		
L 505	322-050.1A PROVIDE PATIENT SERVICES WAC 246-322-050 Staff. The licensee shall: (1) Employ sufficient, qualified staff to: (a) Provide adequate patient services; This Washington Administrative Code is not met as evidenced by: .	L 505		

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L 505	Continued From page 36 Based on interview, document review, and review of hospital policy and procedure, the hospital failed to provide the types and numbers of staff necessary to provide care for all areas of the hospital. Failure to ensure adequate numbers of trained staff is available to provide for mental health therapy in a psychiatric specialized hospital risks patient harm. Findings included: 1. Document review of the hospital's policy titled, "Program Overview/Scope of Care-Inpatient," policy number 5441050, approved 07/19, showed that in patient hospitalization services include group and individual therapy. Therapists provide counseling to each individual that addresses the individual's mental health or substance abuse disorder and motivation, and continuing care needs. Daily involvement in therapy groups and community meetings develops a sense of independence and mutual support that is important in the treatment of all patients in the program. 2. On 09/23/19 at 12:54 PM, Surveyor #5 and a Registered Nurse (Staff #512) reviewed the medical record for Patient #517 who was admitted to the Detoxification Unit on 08/27/19 and transferred to the Inpatient Mental Wellness Unit on 09/02/19 for the treatment of Suicidal Ideation. Documentation in the medical record showed that on the following days, the patient did not receive group or individual therapy because of short staffing: -1 08/31/19, an Activity Group	L 505		

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L 505	Continued From page 37 -2 09/02/19 a Goal-Directed and Semi-Structured Therapy Group (CBT) and Activity Group -3 09/12/19, an Activity Group -4 09/15/19, 2 Activity Groups -5 09/19/19, an Activity Group -6 09/22/19, an Art Therapy Activity Group -7 09/22/19, CBT 3. On 09/23/19 at 3:00, PM, a Registered Nurse (Staff #512) confirmed the finding and stated that the hospital was short on therapy staff and they were unable to do all the therapy groups. 4. On 09/25/19 at 10:17 AM, Surveyor #5 and the Corporate Quality Director (Staff #509), reviewed the medical record for Patient #518 who was admitted on 08/22/19 for the treatment of Unspecified Psychosis. The patient had a history of Schizophrenia, Paranoid Depression, and Type II Diabetes Mellitus. Documentation in the medical record showed that on the following days, the patient did not receive group or individual therapy due to insufficient staff: -1 09/12/19, an Activity Group -2 09/15/19, 2 Activity Groups -3 09/19/19 an Activity Group -4 09/22/19, an Art Therapy Activity Group -5 09/22/19, CBT e. At the time of the review, Staff #509 confirmed	L 505		

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L 505	Continued From page 38 the finding and stated that the hospital has had therapy staff transitioning to other roles in the hospital. .	L 505		
L 520	322-050.2 JOB DESCRIPTIONS WAC 246-322-050 Staff. The licensee shall: (2) Develop and maintain a written job description for the administrator and each staff position; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that therapists were designated as qualified personnel for discharge planning responsibilities. Failure to designate which personnel are qualified to perform discharge planning risks patients receiving inadequate or unsafe discharge plans. Findings included: 1. Document review of the hospital policy and procedure titled, "Discharge and Transition Planning -IP, PHP, IOP, OP," PolicyStat ID # 5586156, last revised 03/19, showed that the hospital engages in ongoing transition planning at the start of services, throughout the course of treatment, and at the time of discharge. Transition planning is documented by use of the Discharge Planning Form. The treating therapist will be responsible for completing the form in its entirety. Document review of the hospital's job description	L 520		

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L 520	Continued From page 39 titled, "Therapist," failed to include any elements of discharge planning as part of the position's job performance standards and responsibilities. 2. On 09/27/19 at 10:30 AM, Surveyor #3 interviewed the Director of Clinical Services (Staff #304) about the discharge planning process. Staff #304 stated that approximately two weeks ago, the hospital stopped using their two designated discharge planners. The hospital reassigned those duties to the therapy staff. Staff #304 also stated that the Therapists are primarily responsible for the development and implementation of the discharge plan. The surveyor asked Staff #304 to review the current therapist job description and identify the discharge planning activities. Staff #304 confirmed there was no specific mention of discharge planning responsibilities in the current Therapist job description. The surveyor also asked Staff #304 to review the hospital's current Therapist Disclosure Statement that lists the licensed therapists and certified counselors on staff. Seven of the twelve individuals identified as having primary responsibilities for supporting the hospital's three inpatient nursing units did not have a license, certification, or education background in social work consistent with training in discharge planning. .	L 520		
L 530	322-050.4 WORK REFERENCES WAC 246-322-050 Staff. The licensee shall: (4) Verify work references prior to hiring staff;	L 530		

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L 530	Continued From page 40 This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to obtain work references prior to employment for 2 of 20 personnel files reviewed (Staff #406, Staff #410). Failure to verify work references prior to employment puts patients at risk of receiving substandard care. Findings included: 1. On 09/26/19 between 8:50 AM and 2:00 PM, Surveyor #4 reviewed personnel files with the Human Resource Manager (Staff #402). The review included the personnel files for two contracted dieticians (Staff #406 and Staff #410). The review showed that neither file contained evidence that the hospital obtained work references prior to hiring the contracted staff. 2. At the time of the review, Staff #402 acknowledged that the hospital had not obtained work references prior to hiring the contracted staff members. .	L 530		
L 545	322-050.6A ORIENTATION-ORG WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (a) Organization of the hospital; This Washington Administrative Code is not met as evidenced by: .	L 545		

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L 545	Continued From page 41 Based on document review and interview, the hospital failed to provide orientation to the hospital organization for 1 of 20 personnel files reviewed (Staff #409). Failure to provide and document orientation to the organization of the hospital for contracted staff puts patients at risk of harm from inadequately trained employees. Findings included: 1. On 09/26/19 between 8:50 AM and 2:00 PM, Surveyor #4 reviewed personnel files with the Human Resource Manager (Staff #402). The review included the personnel file of a Pharmacy Technician (Staff #409) contracted to work in the hospital's pharmacy and on the patient floor. The document review showed that Staff #409 had not received orientation to the hospital or her duties. 2. At the time of the review, Staff #402 acknowledged that the hospital failed to provide appropriate orientation to the contracted employee.	L 545		
L 675	322-060.1 HIV/AIDS TRAINING WAC 246-322-060 HIV/AIDS Education and Training. The licensee shall: (1) Verify or arrange appropriate education and training of staff within thirty days of employment on the prevention, transmission, and treatment of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) consistent with RCW 70.24.310;	L 675		

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L 675	Continued From page 42 This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to provide documentation that staff received appropriate education and training for prevention, transmission and treatment of human immunodeficiency virus (HIV) within 30 days of employment consistent with Revised Code of Washington (RCW) 70.24.310, for 3 of 20 personnel files reviewed (Staff #406,Staff #410). Failure to ensure that staff members have appropriate training for prevention, transmission and treatment of HIV puts patients and staff at risk of harm from infection. Findings included: 1. On 09/26/19 between 8:50 AM and 2:00 PM, Surveyor #4 reviewed personnel files with the Human Resource Manager (Staff #402). Document review of the personnel files for two dieticians (Staff # 406, Staff #410) and one patient care assistant (Staff #411) showed no documented evidence that they received HIV training within 30 days of employment. 2. At the time of the review, Staff #402 stated that the contracted dieticians and the patient care assistant should have documentation of HIV training in their files. .	L 675		
L 810	322-120.6B WATER-TEMPERATURE WAC 246-322-120 Physical Environment. The licensee shall: (6) Provide an adequate supply of hot and cold	L 810		

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L 810	Continued From page 43 running water under pressure meeting the standards in chapters 246-290 and 246-291 WAC, with: (b) Water temperature not exceeding 120 F automatically regulated at all plumbing fixtures used by patients; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to maintain hot water temperature in patient care areas in a way that reduces the risk of scalding during use. Failure to maintain water temperature at 120 degrees Fahrenheit or less puts patients at risk of harm from scalding during hand washing or bathing activities. Findings included: 1. On 09/25/19 at 11:30 AM, Surveyor #4 and the Facilities Manager (Staff #404) entered a patient room in the Sunrise Unit to assess the water temperature at the tap in a patient bathroom. Surveyor #4 used a thin-stemmed thermometer to assess the water temperature at the tap. The observation showed that the thermometer read 124 degrees Fahrenheit. Immediately following the first reading, the surveyor also checked the water temperature at the tap in a bathroom sink in the Administrative Area of the hospital. The thermometer read 123.3 degrees Fahrenheit. 2. At the time of the observation, Staff #404 stated that he was unaware of the water temperature requirement. He reduced the water temperature at the tap during the survey.	L 810		

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L1065	Continued From page 44	L1065		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS 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 retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of policies and procedures, the hospital failed to develop an individualized plan for patient care for 6 of 6 patient plans of care reviewed (Patient #509, #512, #517, #520, #521, and #524). Failure to develop an individualized plan of care can result in the inappropriate, inconsistent, or delayed treatment of patient's needs and may lead to patient harm and lack of appropriate treatment for a medical condition. Findings included: 1. Document review of the hospital's policy and	L1065		

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L1065	Continued From page 45 procedure titled, "Treatment Planning-Philosophy and Purpose," policy number 5063622, approved 01/19, showed that every patient admitted to the hospital will have an individualized plan specific to his or her assessed needs. Care planning includes the development of measurable treatment goals. Care, treatment, and services will be planned, which include patient objectives, staff interventions, services, and treatments necessary to assist the patient in meeting the identified goal. The plan of care, treatment, and services includes: a. Defined Problems b. Measurable goals c. Frequency of care, treatment, and services d. A description of facilitating factors and possible barriers to care e. Criteria for transition f. A plan for discharge g. Documentation of the course of treatment h. Treatment plan review that evaluates patient response to goals and interventions. Document review of the hospital's policy titled, "Program Overview/Scope of Care-Inpatient," policy number 5441050, approved 07/19, showed that Treatment Plans will address lack of participation and interventions will be developed to encourage active participation in treatment. 2. On 09/23/19 at 12:54 PM, Surveyor #5 and a Registered Nurse (Staff #512) reviewed the	L1065		

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L1065	Continued From page 46 medical record for Patient #517. The review showed: a. The patient had a history of chronic low back pain and lower extremity muscle cramps. The patient utilized a wheelchair for mobility. b. On 09/02/19, the patient transferred from Alcohol Detoxification to the inpatient unit for Suicidal Ideation. c. The patient was non-compliant with group therapy attendance. d. On 09/21/19, the patient engaged in an occurrence of Sexually Acting Out (SAO) behavior with a roommate. e. On 09/22/19, the patient became violent and threw a chair at staff. Surveyor #5 found no evidence the patient care plan included defined problems, measurable goals, frequency of care, treatment, and services, a description of facilitating factors and possible barriers to care, or criteria for transition for the problems of altered mobility, substance use disorder treatment, non-compliance, SAO, violent behaviors or pain. 3. At the time of the review, Staff #512 confirmed the care plan was missing the elements. 4. On 09/25/19 at 11:10 AM, during interview with Surveyor #5, an Outpatient Therapist (Staff #519) stated that if patients were not attending groups, they would address it at the treatment team meeting and it should be added to the patient's treatment plan.	L1065		

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L1065	Continued From page 47 5. On 09/25/19 at 11:00 AM, Surveyor #5 and the Corporate Quality Director (Staff #509) reviewed the medical record for Patient #509. The review showed the patient had: a. head lice b. was HIV positive c. had incontinent bloody stool episodes d. was non-compliant with isolation precautions e. had violent behavior episodes f. was non-compliant with therapy group attendance Surveyor #5 found no evidence the patient's treatment plan addressed the problems related to isolation precautions, treatment non-compliance, violent behaviors and non-compliance with therapy groups. 6. At the time of the review, Staff #509 confirmed the finding. 7. On 09/26/19 at 12:00 PM, Surveyor #5 and the Chief Nursing Officer (Staff #506), reviewed the medical record for Patient #524 who was admitted on 08/25/19 for the treatment of Psychosis, Heroin Detoxification, Schizo-Affective Disorder, Cellulitis, and Pain. The review showed the patient was non-compliant with group attendance. Surveyor #5 found no evidence the treatment plan addressed therapy non-compliance. 8. At the time of the review, Staff #506 confirmed	L1065		

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L1065	Continued From page 48 the finding. 9. On 09/26/19 at 1:03 PM, Surveyor #5 reviewed the Medical Record for Patient #520 who was admitted for Opioid Detoxification on 09/03/19. On 09/10/19, the patient was admitted to the Inpatient Mental Health Unit directly after Opioid Detoxification for the treatment of Suicidal Ideation. The patient had a history of Major Depressive Disorder and Unspecified Schizophrenia. The review showed: a. The patient had open wounds (from cutting) to his left wrist. On 09/06/19, a provider order directed staff to perform daily wound care that included daily wound cleaning, application of antibiotic cream, and application of a non-adherent dressing. b. Surveyor #5 found no evidence that the patient's treatment plan addressed the alteration in their skin with daily wound care. Surveyor #5 also found no evidence of opioid addiction support after the patient's initial detoxification. 10. On 09/27/19, Surveyor #5 and the Chief Nursing Officer reviewed the medical records for Patients #512 and #521. The record reviews showed: a. Patient #512 was admitted involuntarily on 07/26/19 for the treatment of Psychosis and violent behavior. The patient was deaf and mute. Review of the Group Therapy notes showed the patient was significantly non-compliant with group therapy attendance. b. Surveyor #5 found no evidence the patient's treatment plan addressed the communication barrier or non-compliance with treatment.	L1065		

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L1065	Continued From page 49 c. Patient #521 was admitted on 09/16/19 for the treatment of Major Depressive Disorder, anxiety and Post Traumatic Stress Syndrome. Review of Group Therapy notes showed the patient was significantly non-compliant with Therapy Group attendance. d. Surveyor #5 found no evidence that the patient's treatment plan addressed Group Therapy attendance non-compliance. 11. At the time of the review, the Chief Nursing Officer (Staff #506) confirmed the treatment plan failed to address therapy non-compliance. .	L1065		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policy and procedures, hospital staff failed to ensure that a licensed provider wrote a complete order for seclusion or restraint for 4 of 5 patient records reviewed (Patient #306, #307, #308, #309) (Item #1) and failed to ensure that	L1150		

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L1150	Continued From page 50 providers did not write orders for restraints as a standing order or that orders for patient restraint were not used on an as-needed basis as demonstrated by 1 of 1 patients reviewed (Patient #512) (Item #2). Failure to follow approved policies and procedures for restraint use puts patients at risk for physical and psychological harm, loss of dignity, and personal freedom. Findings included: Item #1- Incomplete Provider Orders 1. Document review of the hospital's policy and procedures titled, "Seclusion and Restraint," PolicyStat ID # 6516123, last revised 07/19, showed that, in an emergency, the qualified trained Registered Nurse (QRN) can initiate an order for seclusion or restraint as a protective measure provided they obtain a physician's order as soon as possible. The QRN will contact the appropriate licensed independent provider responsible for the care of the patient and write an order for the restraint or seclusion. Providers are not to write "Standing" or "As needed" orders for seclusion and restraint orders. 2. On 09/25/19 at 9:20 AM, Surveyor #3 reviewed the medical records of five patients who were placed in seclusion or restraint during their hospital stay. The review showed the following: a. Patient #309 was a 28 year-old who became severely agitated and began spitting, hitting patient lockers, and banging on the nurse's station. On 04/02/19, staff placed the patient in seclusion between 10:45 AM and 11:15 AM (a 30-minute period). The provider order did not	L1150		

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L1150	Continued From page 51 include the maximum length of time that the patient could remain in seclusion without a new order. b. Patient #308 was a 20 year-old who began shouting and hitting the nurse's station. The patient was physically restrained for administration of an intramuscular injection. On 06/20/19, following the physical hold, staff placed the patient in seclusion between 1:19 PM and 2:04 PM (a 45-minute period). The provider order did not include the maximum length of time the patient could remain in seclusion without a new order. c. Patient #307 was a 45-year-old who was physically restrained after assaulting hospital staff and attempting to break windows to elope from the hospital. On 08/07/19, staff placed the patient in a physical hold between 11:05 PM and 11:45 PM (a 40-minute period). Following the hold, emergency medical personnel transported the patient to a local hospital for evaluation of delirium. The provider order for physical restraint failed to include the length of time the patient could remain held without a new order. d. Patient #306 was a 28-year-old who had an order for "forced medications" if he refused voluntary oral medications. The patient was physically restrained for administration of three intramuscular injections. On 08/22/19, following the physical hold, staff placed the patient in seclusion between 2:03 PM and 2:38 PM (a 35-minute period). The provider order did not include the maximum length of time the patient could remain in seclusion without a new order. Item #2- PRN Orders	L1150		

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L1150	Continued From page 52 1. Document review of the hospital's policy and procedures titled, "Seclusion and Restraint," PolicyStat ID # 6516123, last revised 07/19, showed that, in an emergency, the qualified trained Registered Nurse (QRN) can initiate an order for seclusion or restraint as a protective measure provided they obtain a physician's order as soon as possible. The QRN will contact the appropriate licensed independent provider responsible for the care of the patient and write an order for the restraint or seclusion. Providers are not to write "Standing" or "As needed" orders for seclusion and restraint. 2. On 09/27/19, Surveyor #5 reviewed the medical record of Patient #512 who was admitted involuntarily on 07/26/19 for the treatment of Psychosis and violent behavior. The review showed that on 07/26/19 at 4:45 AM, a provider wrote an order for "restraint as necessary." The provider listed "agitation" as the rationale for the order.	L1150		
L1360	322-210.2 PHARMACY-APPROVAL WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (2) Provide evidence of current approval of pharmacy services by the Washington state board of pharmacy under chapter 18.64 RCW; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to failed to ensure a registered pharmacist supervised the activities of the pharmacy technician during unit dosing of	L1360		

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L1360	Continued From page 53 bulk medications in the main pharmacy. Failure to develop and implement safe medication practice policies, and monitor for quality care, limits the hospital's ability to improve outcomes and puts patients at risk of harm from medication errors and inadequate oversight. Findings included: 1. Document review of the hospital's policy titled, "Restocking the Automatic Dispensing Machine (ADM)," policy number 6219312, approved 07/19, showed that a Licensed Pharmacist or a Registered Technician working under the direct supervision of a Licensed Pharmacist will be responsible for restocking the ADM. Document review of the hospital's policy titled, "Pharmaceutical Services," policy number 6659301, approved 08/19, showed that the Pharmacy is responsible for rendering services in accordance with local, state, and federal laws and regulations, hospital policies and procedures and accreditation standards. 2. On 09/24/19 at 11:50 AM, Surveyor #5, the Director of Pharmacy (Staff #503) and a Pharmacy Technician (Staff #504) reviewed the Pharmacy's unit-dose packaging process. Surveyor #5 reviewed the unit dose log and 4 bins containing medication repackaged by the pharmacy Technician from a bulk container to a unit dose package. Surveyor #5 found no written evidence a Pharmacist had reviewed the medication after repackaging. 3. At the time of the review, during interview with Surveyor #5, Staff #504 confirmed that a Pharmacist did not check the medications she	L1360		

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L1360	Continued From page 54 repackaged prior to placing them back into the pharmacy stock bins. The Director of Pharmacy confirmed that prior to this date, the Pharmacist failed to check the repackaged medications, and failed to verify repackaged medication both in the Pharmacy and in the Automated Drug Dispensing Cabinets. 4. Further discussion regarding the Automated Drug Dispensing Machine cart fills showed that a Pharmacist did not supervise the Pharmacy Technician during the medication pull and cart fill process. 5. At the time of the finding, during interview with Surveyor #5, Staff #504 confirmed that a Pharmacist did not check the medications needed for cart fill. The Director of Pharmacy confirmed that he did not supervise the Technician during this process. He stated that checks were only performed for the narcotics. .	L1360		
L1365	322-210.3A PROCEDURES-MED AUTH WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (a) Assuring professional staff who prescribe are authorized to prescribe under chapter 69.41 RCW; This Washington Administrative Code is not met as evidenced by: . Based on document review, interview, and review	L1365		

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L1365	Continued From page 55 of hospital policies and procedures, the hospital failed to ensure pharmacy kept an accurate controlled substance inventory (Item #1), failed to follow its policies involving discrepancies in controlled substances accounting (Item #2), failed to develop and implement a policy and procedure to identify and ensure suspected staff diversion behaviors prompt necessary investigation and communication to assess patient risk (Item #3), failed to ensure that two nurses completed a daily count of all patient home medication narcotics (Item #4) and failed to monitor, assess and evaluate quality control activities of Pharmacy Services (Item #5). Failure to monitor for quality care and account for and resolve discrepancies in controlled substances accountability risks medication errors, potential diversion for patients and staff and limits the hospital's ability to improve outcomes. Findings included: Item #1- Controlled Substance Inventory Reference: RCW 69.41.042 Record requirements. A pharmaceutical manufacturer, wholesaler, pharmacy, or practitioner who purchases, dispenses, or distributes legend drugs shall maintain invoices or such other records as are necessary to account for the receipt and disposition of the legend drugs. 1. Document review of the hospital's policy titled, "Controlled Substance Administration and Record Keeping," policy number 5253234, approved 10/18, showed that the Director of Nursing and the Pharmacy are responsible for complying with all state and federal regulations dealing with controlled substances. Medications listed in	L1365		

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L1365	Continued From page 56 Schedules III, IV, V, and I are dispensed by the Pharmacy. The policy does not address accountability procedures to ensure control of the distribution, use, and disposition of all scheduled drugs stored in the Pharmacy. 2. On 09/26/19 at 10:15 AM, Surveyor #5, a Pharmacist (Staff #510), the Community Liaison (Staff #511), and the Chief Nursing Officer (Staff #506) conducted a count of 4 random medications in the Scheduled Drug Inventory located in the hospital's main Pharmacy. The review showed 3 of 4 medications counted resulted in discrepancies as follows: a. The Oxycodone 5 mg tablets (a narcotic pain medication) inventory showed that there should have been 270 tablets. A double count by the Pharmacist (Staff #510) and verified by Staff #511 showed 281 tablets, an excess of 11 tablets. Staff #510, #511, and the surveyor reviewed the addition and subtraction for the entire Oxycodone log sheet and found no addition or subtraction discrepancies. Staff were unable to determine how the count was in excess of the amount documented in the log. b. The Amphetamine 20 mg tablets (a controlled medication used to treat attention-deficit hyperactivity disorder (ADHD) and narcolepsy) showed there should have been 75 tablets. A double count by the Pharmacist (Staff #510) and verified by Staff #511 showed 74 tablets, leaving a deficit of 1 tablet. Staff #510, #511, and the surveyor reviewed the addition and subtraction for the entire Amphetamine log sheet and found no addition or subtraction discrepancies. Staff were unable to determine the whereabouts of the missing tablet.	L1365		

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L1365	Continued From page 57 c. The Oxycodone 5 mg/ Acetaminophen 325 mg tablets (a narcotic pain reliever with acetaminophen) showed there should have been 45 tablets. A double count by the Pharmacist (Staff #510) and verified by Staff #511 showed 65 tablets, an excess of 20 tablets. Staff # 510, #511, and the surveyor reviewed the addition and subtraction for the entire log sheet and found no addition or subtraction discrepancies. Staff were unable to determine how the count was in excess of amount documented in the log. 3. At 10:30 AM, the Director of Pharmacy (Staff #503) verified the discrepancies and stated that he was the only person to access, dispense, and return medications to the controlled medication cabinet. He stated he did not know why the counts were not correct unless he returned some controlled medications and forgot to enter it into the log. Item #2- Controlled Substance Discrepancies 1. Document review of the hospital's policy titled, "Controlled Substance Administration and Record Keeping," policy number 5253234, approved 10/18, showed that a physical inventory of all controlled medications shall be conducted by two licensed nurses and documented on the inventory record. All controlled substances in Classes II-V shall be dispensed to the Pyxis Medication Station (Automated drug dispensing cabinet) via an inventory control record (count sheet). If a discrepancy is noted, the nurse will investigate the discrepancy. No nurse is to leave the premises if there is a narcotic discrepancy. If a discrepancy cannot be resolved, the nurse fills out a medication variance report and reports the discrepancy to the Directors of Nursing and Pharmacy for proper investigation. The Pharmacy	L1365		

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L1365	Continued From page 58 will audit the inventory periodically during site inspection for accuracy and completeness. 2. On 09/23/19 at 11:30 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #512) inspected the medication room on an inpatient unit. Surveyor #5 observed the Automated Drug Dispensing Cabinet showed 3 narcotic discrepancies including: a. Methadone 10 mg 1 tablet occurring on 09/16/19 (7 days prior) b. Lorazepam injectable 2 mg/ml occurring on 09/23/19 (1 day prior) c. Lorazepam injectable 2 mg/ml occurring on 09/23/19 (1 day prior) 3. At the time of the observation, Staff #512 stated that the nurse responsible for the discrepancy is supposed to "fix" it. Item #3- Drug Diversion Program Reference: WAC 246-873-080 (7) Controlled substance accountability. The director of pharmacy shall establish effective procedures and maintain adequate records regarding use and accountability of controlled substances, and such other drugs as appropriate, in compliance with state and federal laws and regulations. 1. On 09/25/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #514) inspected the medication room on an inpatient unit. During the inspection, Surveyor #5 observed a Registered Nurse (RN) (Staff #513) remove half of a	L1365		

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L1365	Continued From page 59 Hydromorphone 4 mg tablet (a narcotic pain reliever) for Patient #507 from the Patient-Owned Medication section of the Pyxis. Staff #513 failed to document the narcotic removal on the inventory sheet and left the room. 2. At the time of the observation, Staff #512 stated that the nurse was probably nervous with so many people in the room and should have documented the removal at the time. 3. At this time, further review of the narcotic inventory record showed 22 tablets but a count performed at 3:50 AM showed 22.5 tablets. A physical count performed at the time of the finding by Staff #514 showed only 21.5 tablets. 4. On 09/25/19 at 3:00 PM, the Pharmacy Director (Staff #503) and the Chief Nursing Officer (Staff #506) stated that the 3:50 AM count reflected an undocumented removal of a medication. They also stated that the form in use was flawed, as it did not have a space to write removals. Staff #503 stated that the RN had documented the 2:00 PM removal and the count was now correct. 5. On 09/26/19 at 11:00 AM, Surveyor #5 interviewed the Director of Pharmacy (Staff #503) about the hospital's diversion control program. Staff #503 stated that the hospital did not have an official diversion control program or policy and that neither pharmacy nor nursing conducted audits of controlled substance administration to verify patients received their medications. During the interview, the Chief Nursing Officer (Staff #506) confirmed that the hospital did not conduct audits related to diversion control. Item #4- Complete and Accurate Narcotic Counts	L1365		

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L1365	Continued From page 60 1. Document review of the hospital's policy titled, "Controlled Substance Administration and Record Keeping," policy number 5253234, approved 10/18, showed that a physical inventory of all controlled medications shall be conducted by two licensed nurses and is documented on the inventory record. All controlled substances in Classes II-V shall be dispensed to the Pyxis Medication Station (Automated drug dispensing cabinet) via an inventory control record (count sheet). If a discrepancy is noted, the nurse will investigate the discrepancy. No nurse is to leave the premises if there is a narcotic discrepancy. If a discrepancy cannot be resolved, the nurse fills out a medication variance report and reports the discrepancy to the Directors of Nursing and Pharmacy for proper investigation. The Pharmacy will audit the inventory periodically during site inspection to accuracy and completeness. 2. On 09/23/19 at 12:45 PM, during interview with Surveyor #5, a Registered Nurse (Staff #505) stated that nursing staff are responsible to complete the narcotic counts for patient-owned medications each shift. 3. On 09/24/19 at 11:30 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #512) inspected the medication room on an inpatient unit. Surveyor #5 reviewed the paper "Home Narcotic Log," for 3 narcotic medications brought to the hospital by 2 patients (Patient #507 and #511). The review showed: a. The narcotic log for Patient # 507 for Klonopin 1 mg tablets (potentially habit-forming benzodiazepine used to treat seizures and anxiety) showed that narcotic inventory counts were missing for 5 of 9 shifts including:	L1365		

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L1365	Continued From page 61 -09/20/19 night shift -09/21/19 day shift and night shift -09/22/19 day shift -09/24/19 day shift b. The narcotic log for Patient # 507 for Hydromorphone 4 mg tablets (a narcotic pain reliever) showed that narcotic inventory counts were missing for 5 of 9 shifts including: -09/20/19 night shift -09/21/19 day shift and night shift -09/22/19 night shift -09/24/19 day shift c. The narcotic log for Patient # 511 for Lorazepam 0.5 mg tablets (a benzodiazepines used to treat anxiety disorders) showed that narcotic inventory counts were missing for 22 of 29 shifts including: -09/10/19 night shift -09/11/19 day shift and night shift -09/12/19 day shift and night shift -09/13/19 day shift and night shift -09/14/19 day shift and night shift -09/15/19 day shift and night shift	L1365		

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L1365	Continued From page 62 -09/16/19 night shift -09/17/19 day shift and night shift -09/18/19 day shift and night shift -09/19/19 night shift -09/21/19 day shift and night shift -09/22/19 day shift and night shift -09/24/19 day shift 4. At the time of the review, Staff #512 verified the missing narcotic inventories and stated that the Registered Nurses were to conduct a narcotic count each shift. 5. At the time of the review, the Surveyor observed that the narcotic bottles were packaged in a clear plastic package with a security tape across the top. 6. At the time of the observation, Surveyor #5 interviewed Staff #512 about the security of the medication packages. Staff #512 stated that the nurses accounted for the bottle on the narcotic count; they did not count the medication inside the bottle. Surveyor #5 also asked the staff member how the nurse could be sure the package had not been tampered with or that the seal had not been broken and the bag replaced. Staff #512 stated that she did not know but that it had not been a problem. Item #5- Quality Improvement 1. Document review of the hospital's policy titled, "Organizational Quality Improvement Plan," policy	L1365		

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L1365	Continued From page 63 number 6366314, revised 07/19, showed that patient care and quality control activities of Pharmacy Services are monitored, assessed, and evaluated. The Quality Improvement Program will assess the performance of patient care and organizational functions including Medication Management. Document review of the hospital's policy titled, "Pharmacy and Therapeutics Committee," policy number 6219309, approved 07/19, showed that the Pharmacy and Therapeutics (P&T) Committee oversees and evaluates pharmaceutical services and recommends policies and procedures related to medication use and evaluation, appraisal, selection, procurement, storage, distribution and safe use. The committee reviews data on drug delivery systems, monitors implementation of policy and procedure, reviews reports submitted by the pharmacy, regulatory agencies, nursing, and medical staff related to mediation use process. 2. On 09/26/19 at 9:50 AM, Surveyor #5 and the Pharmacy Director (Staff #503) inspected the hospital's main pharmacy. Surveyor #5 requested the P&T Committee minutes and asked Staff #503 for his medication variance data (wrong medication administration, wrong dose, wrong time, wrong patient etc.). Staff #503 stated that he did not collect this information and that the hospital collected data only on missed medication doses. 3. On 09/29/19, Surveyor #5 reviewed the hospital's P&T Committee minutes for 09/13/18, 10/19/18, 12/05/18, 04/02/19, 07/19/19, and 09/18/19. In the section titled, "P&T Quality Monitors," and in the section titled, "Medication Management Processes," the review showed that	L1365		

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L1365	Continued From page 64 the documentation stated, "Ongoing" in both sections. 4. On 09/29/19, at 9:50 AM, Surveyor #5 asked the Director of Pharmacy (Staff #503) what "ongoing" meant and if he reported medication use and process quality data to the P&T Committee or Quality Committee. Staff #503 stated that he did not because it was an "ongoing process." 5. On 09/30/19 at 2:50 PM, Surveyor #5, the Interim Director of Quality (Staff #508) and the Chief Nursing Officer (Staff #506) reviewed the hospital's Quality Program and meeting minutes. Surveyor #5 observed missed medication dosages reported for 07/19 and 08/19 that contained data from 01/19-06/19. Surveyor #5 found no other evidence that "P&T Quality Monitors," or "Medication Management Processes included collection, aggregation, and analysis of medication use variances, or that results from the analyses were reported to the Quality committee. 6. Document review of the hospital's Quality Minutes, showed no recorded pharmacy activities included in the reports. Instead, the reports contained a repeated placeholder statement that indicated the department would report "next month." 7. At the time of the review, Staff #506 stated that she collected medication errors from incident reports filed by staff and that the hospital had identified that there were areas for significant improvement with their Pharmacy Department processes.	L1365		

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L1370	322-210.3B PROCEDURES-MED ORDERS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (b) Assuring orders and prescriptions for medications administered and self-administered include: (i) Date and time; (ii) Type and amount of drug; (iii) Route of administration; (iv) Frequency of administration; and (v) Authentication by professional staff; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, document review, and review of the hospital's Pharmacy and Therapeutics and Quality Programs, the hospital failed to ensure that practitioners wrote medication orders as directed by hospital policy. Failure to follow hospital policy for order and administration of medications puts patients at risk of harm from medication errors and inadequate oversight. Findings included: 1. Document review of the hospital's policy titled, "Provider Orders," policy number 5253244, approved 10/18, showed that a medication order will contain the medication name, the dose, the route of administration, the frequency of administration, the medication status, the indication or diagnosis, and the date and time of	L1370		

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L1370	Continued From page 66 the order. 2. On 09/25/19 at 11:00 AM, Surveyor #5 and the Corporate Quality Director (Staff #509) reviewed the medical record for Patient #509 who was admitted on 08/26/19 for the treatment of Unspecified Psychosis and Stimulant Abuse. The review showed that on 08/30/19 at 2:30 PM, a provider ordered an intramuscular (IM) injection of "B52" (A drug cocktail named for ("Benadryl", "5" mg haloperidol and "2" mg of lorazepam, or consisting of 50 mg of an anticholinergic, either haloperidol or droperidol, plus 2 mg of a benzodiazepine) for either "agitation" or "if the patient refused (their other) medication by mouth". Document review of the medication administration records showed "B52" handwritten in the "as needed" (PRN) order section. Surveyor #5 found no evidence the provider clarified the order to determine the specific medications and medication doses the patient should receive. 3. At the time of the observation, Staff #509 stated that the provider should have clarified the order. 4. On 09/25/19 at 9:20 PM, Surveyor #3 reviewed the medical record of Patient #306 who was admitted on 08/17/19 for the treatment of Unspecified Psychosis. The review showed that on 08/22/19 at 2:00 PM, a Registered Nurse wrote a telephone order for a provider to "Give B52 IM now." Surveyor #3 found no evidence the provider order was clarified to determine the specific medications and medication dosages the patient should receive. .	L1370		

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L1375	Continued From page 67	L1375		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, document review, and review of the hospital's Pharmacy and Therapeutics and Quality Programs, the hospital failed to develop and implement Pharmacy policies and procedures to minimize drug errors. Failure to develop and implement safe medication practice policies limits the hospital's ability to improve outcomes and puts patients at risk of harm from medication errors and inadequate oversight. Findings included: 1. On 09/24/19, Surveyor #5 requested the hospital's policy for "Override Medications." Surveyor #5 received a typewritten list titled "Addendum A-Medication Override List," no date provided. 2. On 09/27/19 at 12:30 PM, Surveyor #5, the Chief Nursing Officer (Staff #506), and a Registered Nurse (Staff #507) reviewed all medications available for removal from the	L1375		

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L1375	Continued From page 68 automated drug dispensing cabinet (ADC) and compared those medications to both the list provided to the surveyor and to a list posted on the wall behind the ADC. Surveyor #5 observed the ADC contained 16 additional medications available for removal that were not on the list provided to the surveyor. The additional drugs included: a. Alprazolam 0.5 mg tablet (a controlled medication used to treat anxiety) b. Clonazepam 0.5 mg tablet (a medication used to prevent and control seizures) c. Clonazepam 1.0 mg tablet d. Haldol 1 mg tablet (an antipsychotic medication used to treat psychotic disorders) e. Haldol 5mg tablet f. Ibuprofen 400 mg tablet g. Losartan 25 mg tablet (a medication used to treat high blood pressure and to help protect the kidneys from damage due to diabetes) h. Seroquel 50 mg tablet (an anti-psychotic medication used to treat mental and mood disorders) i. Temazepam 50 mg tablet (a benzodiazepine medication used to treat insomnia) j. Temazepam 30 mg tablet k Tramadol 50 mg tablet (a narcotic-like pain reliever used to treat moderate to severe pain in adults)	L1375		

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L1375	Continued From page 69 l. Trazadone 100 mg tablet (an antidepressant medication) m. Ziprasidone 50 mg tablet (an atypical antipsychotic used to treat mental and mood disorders) n. Ziprasidone 100 mg tablet o. Ziprasidone 20 mg tablet p. Zolpidem 10 mg tablet (a sedative used to treat insomnia) 3. At the time of the observation, Staff #507 confirmed the observation and verified that she could remove all 16 medications from the ADC without first obtaining a physician order. 4. On 09/27/19 at 1:00 PM, the Chief Nursing Officer (Staff #506) confirmed that the hospital did not have an Override Medication Policy that defined the medications approved for override and that the Override List provided to the surveyor had not received approval from the hospital's Pharmacy and Therapeutics committee.	L1375		
L1390	322-210.3F PROCEDURES-AUTHENTICATE WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (f)	L1390		

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L1390	Continued From page 70 Authenticating verbal and telephone orders by prescriber in a timely manner, not to exceed forty-eight hours for inpatients; This Washington Administrative Code is not met as evidenced by: . Based on document review and review of the hospital's medical staff rules and regulations, the hospital failed to ensure that healthcare providers authenticated orders for care and treatment of patients according to the hospital's medical staff rules and regulations. Failure to write and authenticate orders for medications and treatment risks provision of incorrect and/or inadequate patient care. Findings included: 1. Document review of the hospital's policy titled, "Medical Staff Rules and Regulations," policy number 5612049, approved 03/19, showed that all orders must be authenticated, dated, and timed by the Physician or Allied Health Professional issuing the order. The attending Physician will co-sign, as soon as possible and in accordance with hospital policy. All verbal orders will be read back to the provider and so noted in the medical record. The ordering provider will authenticate all verbal within the state-specified time frame. Document review of the hospital's policy titled, "Provider Orders," policy number 5253244, approved 03/19, showed that the physician would sign written orders within 48 hours. 2. On 09/23/19 at 12:54 PM, Surveyor #5, a Registered Nurse (Staff #512), and the Director	L1390		

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L1390	Continued From page 71 of Ancillary and Outpatient Services (Staff #516) reviewed the medical record for Patient #517 who was admitted on 08/27/19. The review showed that provider had not authenticated their telephone orders within 48 hours on the following dates and times: a. 08/28/19 at 1:43 PM b. 08/29/19 no time c. 08/30/19 at 10:50 AM d. 08/31/19 at 11:10 AM e. 09/02/19 no time f. 09/02/19 at 2:11 PM g. 09/02/19 no time h. 09/03/19 at 2:16 PM i. 09/06/19 at 10:24 AM j. 09/10/19 at 2:15 PM k. 09/10/19 at 4:50 PM l. 09/11/19 at 3:50 PM 3. On 09/25/19 at 9:20 AM, Surveyor #3 reviewed the medical records of five patients who were placed in seclusion or restraint during their hospital stay (a period of 03/19 to 08/19). The review showed the that the provider had not authenticated telephone orders given to the nursing staff for restraint or seclusion for Patient's #306, #307, #308, #309, and #310.	L1390		

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L1390	Continued From page 72 4. On 10/01/19 at 8:15 AM, Surveyor #3 reviewed the medical record of Patient #311 who was admitted on 03/15/19. The review showed that the provider had not authenticated telephone orders given to the nursing staff on admission given for Admission Medication Reconciliation/Admission Medication Orders and the Subcutaneous and Correctional (Sliding Scale) Insulin Orders. .	L1390		
L1395	322-210.3G PROCEDURES-USE OF MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (g) Use of medications and drugs owned by the patient but not dispensed by the hospital pharmacy, including: (i) Specific written orders; (ii) Identification and administration of drug; (iii) Handling, storage and control; (iv) Disposition; and (v) Pharmacist and physician inspection and approval prior to patient use to ensure proper identification, lack of deterioration, and consistency with current medication profile; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of hospital policy and procedure, the hospital failed to ensure that a pharmacist verified patient-owned medications to identify and verify	L1395		

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L1395	Continued From page 73 integrity of the medication for 9 of 9 patients with patient-owned medications (Patient #301, #302, #303, #304, #506, #507, #508, #509, and #510). Failure to verify patient medication brought from home puts patients at risk of harm or death from medication errors. Findings included: 1. Document review of the hospital's policy and procedure titled, "Administration of Own/Personal Medications," policy number 4890035, approved 05/18, showed that medications brought to the hospital by the patient will not be administered until a pharmacist identifies the medication, verifies its integrity via visual inspection, and adds a label that includes the patient's name, one other identifier, and the patient location. The pharmacist will attach a supplemental label to the container to verify that the medication is approved for administration. During hours when the Pharmacy is closed, the attending physician, another responsible practitioner, or Nurse Supervisor may make the approval. Document review of the hospital's policy and procedure titled, "Medical Staff Rules and Regulations," PolicyStatID # 5612049, approved 03/19, showed that the attending physician may order a home medication to be used; however, it must be verified by the pharmacy according to the hospital policy. 2. On 09/23/19 at 12:30 PM, Surveyor #3 inspected the "Meadows" inpatient nursing unit medication room with the Director of Nursing (Staff #301). The observation showed the following non-verified patient-owned medications stored in the Pyxis (automated medication	L1395		

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L1395	Continued From page 74 dispensing machine) cabinet: a. Olanzapine ODT 20 mg tablets in a pharmacy blister package card with a non-hospital prescription label for Patient #301. b. Fluphenazine 1 mg tablets in a non-hospital pharmacy blister package card with a prescription label for Patient #301. c. Eliquis 5 mg tablets in a non-hospital pharmacy blister package card with a prescription label for Patient #301. d. Fluphenazine 1 mg tablets in a bottle with a non-hospital prescription label for Patient #301. e. Latuda 80 mg tablets in a bottle with a non-hospital prescription label for Patient #302. f. Advair Diskus inhaler with a non-hospital prescription label for Patient #303 g. Proair HFA inhaler with a non-hospital prescription label for Patient #303. 3. On 09/23/19 at 1:00 PM, Surveyor #3 interviewed a registered nurse (Staff #302) about patient-owned medications. Staff #302 stated that patient-owned medications could be administered if the provider writes an order authorizing their usage. Nursing or Pharmacy staff visually verified patient-owned medications and placed them in the Pyxis machine. Surveyor #3 asked the nurse if they require any supplemental label or marking to document visual verification. Staff #302 stated that they did not, but explained patient-owned medications may only be placed in the Pyxis storage cabinet if there has been a visual verification.	L1395		

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L1395	Continued From page 75 4. On 09/24/19 at 11:00 AM, Surveyor #3 inspected the "Sunrise" inpatient nursing unit with Staff #301. The observation showed the following non-verified patient-owned medications stored in the Pyxis (automated medication dispensing machine) cabinet: a. Atazanavir 30 mg capsules in a bottle with a non-hospital prescription label for Patient #304 b. Ritonavir 100mg tablets in a bottle with a non-hospital prescription label for Patient #304. c. Emtricitabine 200 mg and Tenofovir 300mg tablets with a non-hospital prescription label for Patient #304. 5. On 09/24/19 at 11:20 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) inspected the Automated Medication Dispensing Cabinet located in the inpatient Cedar Unit. The observation showed 8 patient-owned medications belonging to 5 patients (Patient #506, #507, #508, #509, and #510) that did not contain a hospital pharmacy label or evidence of verification by a pharmacist prior to administration to the patient. 6. At the time of the observation, Surveyor #5 asked Staff #505 to describe the hospital policy for verifying patient-owned medications. Staff #505 stated that she did not know. 7. On 09/24/19 at 11:58 AM, Surveyor #5 interviewed the hospital's Director of Pharmacy (Staff #503) about pharmacy verification of patient-owned medications. Staff #503 stated that he checked every patient-owned medication. Surveyor #5 asked Staff #503 about the unverified medications located on the Cedars Unit	L1395		

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L1395	Continued From page 76 drug-dispensing machine. Staff #503 stated that he checked patient-owned medications but that it was a "work in progress" and that he was not "100% at checking." .	L1395		
L1400	322-210.3H PROCED-MEDS IN PATIENT AREAS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (h) Maintaining drugs in patient care areas of the hospital including: (i) Hospital pharmacist or consulting pharmacist responsibility; (ii) Legible labeling with generic and/or trade name and strength as required by federal and state laws; (iii) Access only by staff authorized access under hospital policy; (iv) Storage under appropriate conditions specified by the hospital pharmacist or consulting pharmacist, including provisions for: (A) Storing medicines, poisons, and other drugs in a specifically designated, well-illuminated, secure space; (B) Separating internal and external stock drugs; and (C) Storing Schedule II drugs in a separate locked drawer, compartment, cabinet, or safe; This Washington Administrative Code is not met as evidenced by: .	L1400		

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L1400	Continued From page 77 Based on observation, interview, document review, and review of the hospital's Pharmacy and Therapeutics and Quality Programs, the hospital failed to accurately perform monthly unit inspections (Item #1) and failed to ensure appropriate labeling for medications dispensed as unit doses (Item #2). Failure to perform monthly unit inspections and ensure appropriate medication labeling risks harm from patients receiving medication errors. Findings included: Item #1- Unit Inspections Reference: WAC 246-873-080 (1) (b) A monthly inspection of all nursing care units or other areas of the hospital where medications are dispensed, administered or stored. Inspection reports shall be maintained for one year. 1. On 09/24/19 at 11:20 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) inspected the Automated Medication Dispensing Cabinet located in the inpatient Cedar Unit. Surveyor #5 observed 8 patient-owned medications belonging to 5 patients (Patient #506, #507, #508, #509, and #510) that did not contain a hospital pharmacy label or show they had been verified by a pharmacist prior to administration to the patient as a patient-owned medication. Surveyor #5 asked Staff #505 to describe the hospital policy for verification of patient-owned medications. Staff #505 stated that she did not know. 2. On 09/24/19 at 11:58 AM, Surveyor #5 interviewed the hospital's Director of Pharmacy (Staff #503) about pharmacy verification of patient-owned medications. Staff #503 stated that	L1400		

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L1400	Continued From page 78 he checked every patient-owned medication. Surveyor #5 then asked Staff #503 about the unverified medications located on the Cedars and Meadow Units. Staff #503 stated that it was a "work in progress" and that he was not "100% at checking." 3. On 09/26/19 at 9:50 AM, Surveyor #5 and the Pharmacy Director (Staff #503) inspected the hospital's Nursing Care Unit inspection reports, located in the main pharmacy. The inspection reports for all 3 inpatient units from 11/18 to current (a period of 11 months) contained documentation to indicate that the pharmacist checked to ensure that a patient-owned medication was clearly labeled, verified, and within date. Surveyor #5 asked if staff correctly completed the unit's inspection logs, as the surveyor had already observed on the inpatient units, that pharmacy verification of medication prior to administration to the patient was not the hospital's current process. Staff #503 stated that they were, but that he was not 100% compliant with completion of the verification. He was not able to answer why the documentation on the Unit inspection reports showed 100% compliance. Item #2- Misbranding of Repackaged Medication Reference: 21 US Code §352 Misbranded drugs and devices: A drug or device shall be deemed to be misbranded-(a) False or misleading label ... (g) Representations as recognized drug; packing and labeling; inconsistent requirements for designation of drug (i) Drug; misleading container; imitation; offer for sale under another name WAC 246-873-080(5) (a) (5) Labeling: (a)	L1400		

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L1400	Continued From page 79 Inpatient. All drug containers in the hospital shall be labeled clearly, legibly and adequately to show the drug's name (generic and/or trade) and strength when applicable. Accessory or cautionary statements and the expiration date shall be applied to containers as appropriate. 1. On 09/24/19 at 11:50 AM, Surveyor #5 observed pharmacy re-packaged unit-dose medications containing both the generic and trade names of the product. Bulk bottles in the bins with the unit-dose medications showed generic medications. The observation showed: a. Unit-dosed medication labeled as both Estradiol and Estrace 0.5 mg tablet. The corresponding bottle located with the medication contained the generic Estradiol. b. Unit-dosed medication labeled as both Prazosin HCL and Minipress 1 mg capsule. The corresponding bottle located with the medication contained the generic Prazosin HCL. c. Unit-dosed medication labeled as both Prazosin HCL and Minipress 1 mg capsule. The corresponding bottle located with the medication contained the generic Prazosin HCL. d. Unit-dosed medication labeled as both Metoprolol Succinate and Toprol XL 50 mg tablet. The corresponding bottle located with the medication contained the generic Metoprolol Succinate. 2. At the time of the observation, Staff #503 stated that the hospital only purchased generic drugs and that it was easier for the nurses to have both the generic and a trade name. He stated that he was unaware that he could not use	L1400		

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L1400	Continued From page 80 both the generic and the trade name when repackaging medications. .	L1400		
L1410	322-210.3J PROCEDURES-OUTDATED MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (j) Prohibiting the administration of outdated or deteriorated drugs, as indicated by label; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to ensure that staff labeled patient inhalers with the beyond use date after removing the medication from the foil packaging, as directed by the manufacturer for 3 of 3 inhaled medications observed. Failure to ensure that staff label inhaled medications with an expiration date risks that expired medications are available for patient administration and creates a risk of harm to the patient. References: GlaxoSmithKline, Advair HFA package insert, 01/09: Safely discard ADVAIR HFA 12 months after you remove it from the foil pouch, or after the dose indicator reads "0," whichever comes first.	L1410		

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L1410	Continued From page 81 GlaxoSmithKline, Ventolin HFA (Albuterol Sulfate Inhalation Aerosol) package insert, 2017: Throw the inhaler away when the counter reads 000 or 12 months after you opened the foil pouch, whichever comes first. Findings included: 1. On 09/24/19 at 11:20 AM, Surveyor #5 and a Registered Nurse (Staff #505) inspected the patient-owned medication section of the automated drug dispensing cabinet. The observation showed 2 opened albuterol inhalers and 1 opened Advair inhaler that did not contain the beyond use date (BUD) as directed on the drug labels. 2. At the time of the observation, Staff #505 verified the finding and stated that nursing is responsible to put a date on the inhalers when opened. .	L1410		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview and document review, the hospital failed to ensure that dietary staff members maintained compliance with the Washington State Retail Food Code (Washington Administrative Code (WAC) 246-215.	L1485		

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L1485	Continued From page 82 Failure to maintain compliance with the Washington State Retail Food Code puts patients, visitors and staff at risk of harm from food-borne illness. Findings included: 1. Document review of the hospital's policy titled, "Dietary Services- Health and Hygiene Standards," last reviewed 09/19, showed that employees shall thoroughly wash hands and the exposed portions of their arms with soap and warm water during work, as often as necessary to keep them clean. 2. On 09/24/19 at 10:15 AM, Surveyor #4 observed a member of the dietary staff (Staff #408) as he carried out multiple tasks in the kitchen, including food preparation and stocking of incoming products. The observation showed that the staff member failed to change gloves and perform hand hygiene between tasks. Reference: WAC 246-215-02310 (6) 3. On 09/24/19 at 10:00 AM, Surveyor #4 toured the hospital kitchen. While inspecting the walk-in refrigerator, the surveyor observed several cooked items including turkey filets and meat chili. The observation showed that the cooked items were in the walk-in refrigerator cooling in pans greater than 2 inches deep. 4. At the time of the observation, the Surveyor asked Staff #406 if she had a cooling log to document that the items cooling in the pans had reached an internal temperature of 41 degrees Fahrenheit or less within six hours of placement in the walk-in, since the items were in pans of greater than two inches of depth. Staff #406	L1485		

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L1485	Continued From page 83 stated that she did not maintain a cooling log for the items. Reference: WAC 246-215-03515	L1485		
L1520	322-230.2G FOOD SERVICE-DIET MANUAL 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: (g) Maintaining a current diet manual, approved in writing by the dietitian and medical staff, for use in planning and preparing therapeutic diets; This Washington Administrative Code is not met as evidenced by: . Based on interview, the psychiatric hospital failed to provide a current therapeutic diet manual to clinical and food service staff that had been approved by the dietician and physicians. Failure to provide a current therapeutic diet manual to staff in order to guide patient nutritional services puts patients at risk of harm from improper or substandard diets. Findings included: On 9/24/19 at 10:00 AM, Surveyor #4 interviewed the Dietary Manager (Staff #406) and requested to see the current therapeutic diet manual. Staff #406 stated she did not have a therapeutic diet manual for the hospital and had received patient menus from another hospital in the hospital's corporate system.	L1520		

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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 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 document review and interview, the hospital failed to ensure that patient menus were identified by year, and contained all foods, including snacks, that contributed to the patients' nutritional requirements. Failure to provide patient menus identified with complete dates (including year) and contain all nutritional information puts patients at risk of harm from inadequate nutrition. Findings included: 1. Document review of the hospital's weekly menus for patients showed that they reflected the month and day, but not the relevant year, as required by the State of Washington Administrative Code.	L1525		

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L1525	Continued From page 85 2. On 09/24/19 at 9:50 AM, Surveyor #4 interviewed the Dietary Manager (Staff #406) about menu creation for the hospital's patients. Staff #406 stated that she received menus from another hospital in the hospital's corporate system, as the previous dietary manager failed to provide them. She also stated she was unaware that menus needed to have full dates, including the year, and that all patient snack options that contribute to the patients' total nutritional requirements have to be listed as part of the patient menu.	L1525		
L1565	322-240.4A LAUNDRY-WATER TEMPERATURE WAC 246-322-240 Laundry. The licensee shall provide: (4) When laundry is washed on the premises: (a) An adequate water supply and a minimum water temperature of 140 F in washing machines; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to maintain the water temperature in washing machines used for patient laundry at a minimum temperature of 140 degrees Fahrenheit as required by the Washington Administrative Code for this facility type. Failure to maintain an adequate hot water temperature for patient clothing puts patients at risk of harm from unsanitary, unclean clothes. Findings included: 1. On 09/23/19 between 11:30 AM and 1:15 PM,	L1565		

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	013220	A. BUILDING: _____ B. WING _____	10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L1565	Continued From page 86 Surveyor #4 toured the Cedars and Meadow units of the hospital. The observation showed that patients do their own laundry in designated laundry rooms in each unit. 2. On 09/25/19 at 9:50 AM, Surveyor #4 interviewed the Facilities Manager (Staff #404) about the water temperature used for the washing machines in the patient units. The surveyor asked if the machines used a booster or some other means to ensure that the water temperature reached 140 degrees Fahrenheit. Staff #404 stated that the hot water temperature in the machines was the same as for patient care area sinks.	L1565		

State of Washington

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S 000	Initial Comments This report is the result of an unannounced Fire and Life Safety survey conducted at Rainier Springs on 09/23/2019-09/25/2019 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health. The facility has a total of 72 beds and at the time of this survey the census was 51. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a single story type 2B construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Nicholas D. Wolden 1823 Baker Way Kelso, WA (360) 852-0966 35231 Deputy State Fire Marshal	S 000		
S 291	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based upon observations and staff interviews on	S 291		

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S 291	Continued From page 1 09/24/2019 between approximately 0800 to 1500 hours the facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of the battery powered backup lighting in the event of a power outage and render the means of egress dark. This could result in tripping and fall injuries to patients, staff and/or visitors. The findings include, but are not limited to: The facility failed to provide documentation of emergency light testing from December 2018-July 2019. The facility states that they will start testing the emergency lighting again. The above was discussed and acknowledged by the facility staff.	S 291		
S 324	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	S 324		

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S 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based upon record review and staff interviews on 09/24/2019 between approximately 0800 to 1500 hours the facility has failed to maintenance of the hood and duct fire suppression equipment protecting the commercial cooking equipment. This could result in the failure of the system to operate properly which would endanger the patients, staff and/or visitors within the facility. The findings include: The facility failed to provide a heat survey for the Ansul R102 type one hood system. Fusible links were found to be 5 (360 degree) and 1 (450 degree) link. The facility provided me with a current 6 month inspection report for hood system. The above was discussed and acknowledged by the facility staff.	S 324		
S 761	NFPA 101 Maintenance, Inspection, and Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	S 761		

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S 761	Continued From page 3 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is not met as evidenced by: Based on observation and staff interview on 09/24/2019 between approximately 0900 to 1500 hours the facility has failed to maintain openings in fire and smoke rated walls. This could lead to the rapid spread of fire and smoke throughout the facility endangering patients, staff, and visitors. The findings include, but are not limited to: The facility failed to conduct annual fire door inspections. The facility states that they have the annual fire door inspection scheduled for October 2, 2019. The above was discussed and acknowledged by the facility staff.	S 761		
S 914	NFPA 101 Electrical Systems Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional	S 914		

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S 914	Continued From page 4 testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview on 09/24/2019 between approximately 0900 to 1500 hours the facility failed to keep records or conduct maintenance on their hospital grade receptacles. This could cause an increased risk of fire due to the non-maintenance of the electrical system and endanger patients, staff, and visitors. The findings include:	S 914		

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S 914	Continued From page 5 Facility failed to provide documenation of electrical receptials. EOC manager states that he was unaware of the requirements. NFPA 99, 2012 6.3.4.1 Maintenance and Testing of Electrical System. 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. The above was discussed and acknowledged by the facility staff.	S 914		
S 920	NFPA 101 Electrical Equipment Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for	S 920		

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S 920	Continued From page 6 non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview on 09/24/2019 between approximately 0800 to 1500 hours the facility failed to restrict the use of extension cords and non-approved power strips in their facility. This could endanger patients, staff, and visitors in the facility due to the increased fire risk. The findings include: Keurig found to plugged into a powerstrip in assessment area. Removed during inspection Extension cord found in room 157 being used	S 920		

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S 920	Continued From page 7 permanent wiring. Removed during inspection The above was discussed and acknowledged by the facility staff.	S 920		
S 926	NFPA 101 Gas Equipment Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview 09/24/2019 between approximately 0900 to 1500 hours the facility has failed to provide documentation of personnel concerned with the application, maintenance, and handling of medical gases and cylinders that are trained on the risk and provide continuing education. Failure to provide training and continuing education on the safe handling and use of gases and cylinders could place patients, visitors, and staff at risk of oxygen malfunctions.	S 926		

State of Washington

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S 926	Continued From page 8 The findings include: The facility failed to provide documentation that personnel that handle medical gases received continuing education. The above was discussed and acknowledged by the facility staff.	S 926		

POC Rcvd 11/1/19

Rainier Springs DOH Plan of Correction
Survey Completed on 10/1/19

Revised POC Approved 12/3/19

	DOH	Standard Cited	Action Plan and prevention of recurrence	Process (Education/Training)	Monitoring and Tracking	Sample Size	Audit	Target for Compliance	Out of Compliance Follow up	Responsible Person	Date
1	L210	322.030.3A BACKGROUND STAFF	HR will ensure that a Washington State patrol criminal history background will be completed prior to starting employment.	HR manger will be educated to conduct Washington State patrol criminal history background on all new employees prior to starting employment.	100% of new employees will be audited by HR for their Washington State patrol criminal history background for the next 120 days.	100% of new employees	Numerator: Employees with WATCH completed Denominator: # of employees	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Andrea Chepkwony, Manager of HR	10/28/19
2	L315	322.035.1C POLICIES - TREATMENT	1. Nurses will document any change of condition when a patient is transferred to a higher level of care. Nurses will also document a re-assessment of patients after they return to our hospital from a higher level of care. House supervisors will audit 100% of charts for patients who transferred to a higher level of care and when a patient returns from a higher level of care to ensure proper documentation.	1. Nurses will be educated on how to document when a patient has a change of condition or patient returns from higher level of care and needs re-assessment. Education started on 10/25/19 and will continue in shift huddle until every working nurse has read and signed the protocol by 11/14/19.	1. DON will audit 100% transfers each month for 4 months to ensure 90% compliance or greater.	100% of charts (up to 10 charts) for patients who transferred to a higher level of care and when a patient returns from a higher level of care to ensure proper documentation.	Numerator: # of charts with follow up/ Denominator: # of sample size (10 charts)	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	2. Nurses will document and notify provider regarding any vital signs that are out of the admission order parameters.	2. Nurses will be re-educated on policy #5382582 Vital signs and weight". Education started on 10/23/19 and will continue in shift huddle until every working nurse has read and signed the protocol by 11/14/19. They will also be educated on ensuring they are following providers orders with regard to vital signs.	2. House Supervisors, charge nurses, and/or DON will audit all vital signs and orders per shift to ensure compliance on proper follow-up of vital signs and documentation of notifying the provider of abnormal findings as ordered for next 4 months	10 charts (or # of orders that indicate need for follow up)	Numerator: Followed up on vital as ordered Denominator: 10 charts audited	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	3. Nurses will follow safe medication practices.	3. Nurses will be re-educated on safe medication administration, education started on 10/24/19 and will continue in shift huddle until every working nurse has read and signed the protocol by 11/14/19.	3. House Supervisors/Charge Nurses/Director of Nursing will audit 5 staff medications dispenses weekly to ensure safe medication administration was completed 4 months.	5 medication dispenses weekly	Numerator: Safe medication dispense Denominator: 5 observation	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	4. Nurses will initiate pain assessment, and pain reassessment.	4. Nurses will be re-educated on pain assessments and reassessment. Education started on 10/24/19 and will continue in shift huddle until every working nurse has read and signed the protocol by 11/14/19.	4. House Supervisors/Charge Nurses/Director of Nursing will audit 5 charts a day to ensure pain assessment and re-assessment compliance for 4 months.	5 charts daily	Numerator: Pain assessments and re-assessment has compliant documentation Denominator: 5 Charts	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	5. Nurses will monitor and administer insulin as directed by provider orders.	5. Nurses will be re-educated on glucose monitoring and insulin administration/documentation.	5. House Supervisors/Charge Nurses/Director of Nursing will complete daily audits on 100% of insulin dependent diabetic charts daily to ensure compliance for 4 months.	100% of diabetic patients	Numerator: Compliance with provider orders regarding diabetic patients Denominator: # of diabetic pts	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	6. Assessment staff will complete a medical screening within 15 minuets for all patients who walk-in and document appropriate outcomes of medical screening.	6. Training provided to Assessment staff on 9/3 and 10/24 on EMTALA as well as appropriate documentation of medical screening and maintaining copies of EMTALA Transfer logs/medical screenings.	6. EMTALA audit will be conducted weekly for the next 4 months If a copy of transfer form is missed or not copied an attempt to get copy from accepting facility will be done or documentation that an attempt was done.	100% of transfers to have EMTALA transfer paperwork completed. 100% will also have medical screening complete	Numerator: Compliant EMTALA Transfers completed from Assessment Denominator: Number of transfers from Assessment Numerator: Completed medical screenings for transfers Denominator: Number of transfers from Assessment	90% or greater for EMTALA transfers documentation completed 90% or greater for medical transfers completed	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	7. When a patient meets criteria on admission SAO will be documented on the SBAR. If a patient has sexually acting out behaviors during their stay SAO precautions will be ordered, and SAO will be added to treatment plan by clinical staff or RN. SAO precautions will be re-assessed every 24 hours by RN. SAO check list will be completed as well.	7. Re-Education to clinical staff and RN staff on Sexually Acting Out (SAO) Policy # 6005832. SOA check list was reviewed as well.	7. The AOC will monitor via rounds or camera review on every unit 2x weekly for sexually acting out behavior and trace needed SAO precautions. 100% of patients on SAO precautions will be audited for the next 4 months to ensure precautions were appropriately ordered, were re-assessed and discontinued per policy	100% of patients on SAO precautions will be reviewed to ensure: *start or stop order present *patient reassessed daily by physician	Numerator: # of compliant SAO precautions (per policy) Denominator: # of patients on SAO precautions	90% or greater	Noncompliant SAO orders or assessments will result in immediate notification of physician for order and for face to face with physician within 24 hours.	Caroline Rath, Director of Nursing	10/25/19
2	L315	322.035.1C POLICIES - TREATMENT	8. Each unit will have access to Google Chrome book for immediate interpretive services needs. Facility will attempt to secure in person interpretive services through facilities contracted services.	8. All clinical and assessment staff will be educated on how to use Google Chrome books for accessing language line app and will be educated on how to contact the facilities in person contracted interpreters.	8. 100% of patients who require interpreters will be audited. The audit will include when the patient arrived, when the interpreter was contacted, for each day. The audit will be conducted for the next 4 months.	100% of patients who require interpretive services	Numerator: # of patients provided interpretive services Denominator # of patients requiring services	90% or greater	Instances of noncompliance will be reviewed daily appropriate corrective follow-up	Caroline Rath, Director of Nursing	10/25/19

Rainier Springs DOH Plan of Correction
Survey Completed on 10/1/19

	DOH	Standard Cited	Action Plan and prevention of recurrence	Process (Education/Training)	Monitoring and Tracking	Sample Size	Audit	Target for Compliance	Out of Compliance Follow up	Responsible Person	Date
3	L320	322.035.1D POLICIES-PATIENT RIGHTS	Director of Quality will ensure the grievance process is followed per policy. Patients who write a grievance will get a notice within 15 days which will include: (1) The name of the Hospital contact (2) The steps taken on behalf of the individual to investigate the complaint (3) The results of the process (4) The date of completion of the complaint process (5) The steps to take if dissatisfied with the outcome	1. Hospital staff will educated on the grievance process. Director of Quality was educated on the policy and will follow General Grievance process as indicated in policy.	100% of grievances will be monitored via the grievance log for the next 4 months. The audit will indicate date of grievance, date responded, and if all elements were documented in response to the grievance.	100%	Numerator: # of grievances addressed per policy Denominator: Total number of grievances	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Heather Hernandez, Director of Quality	11/1/19
4	L360	322-035.1L POLICIES - SMOKING	New signs up stating "No Smoking within 25ft"	EOC manager put signs up.	100% of all signs were changed.	100%	EOC manager will ensure presence of appropriate signage during monthly environmental rounds	100%		Cole Johnson, EOC Manager	10/20/19
5	L435	322.040.4 ADMIN-ADMINISTRATOR	Governing Board appointed CEO on 10/1/19. CEO will participate in CEO orientation and competencies. Administration department orientation to include notification of Governing Board for all new CEO via an Appointment Letter.	CEO was appointed by Governing Board during a special meeting via telephone on 10/1/19.	Governing Board appointed Jeff Serrano as CEO to Rainier Springs on 10/1 during survey. HR will monitor CEO HR file to ensure CEO competencies have been completed. Competency checklist will be monitored by Administrative assistant for all new appointees.	100%	Governing Board will convene and approve new CEO appointees within 7 days of first date of hire. Appointment will documented in BOG minutes.	100%	Documented follow up and action plan by BOG chairperson will occur monthly for noncompliant items.	Jeff Serrano, CEO	10/1/19
6	L495	322.040.81 ADMIN RULES-PERFORM EVALS	1. The facility's quality program is implemented and will include aggregated data regarding Medication Errors, Medication Management, Pharmacy and Therapeutics Function, Safety Management, Risk Management, Infection Control, Utilization Management, Clinical Laboratory Services, Nursing Services, Nutritional Services, Pharmacy Services, Therapeutic and Discharge Planning and analyze trends and determine if any process improvement is needed and ensure benchmarks have been reached.	1. Quality Director will collect monthly data from leadership members; Quality council will analysis data and determine appropriate action plans are in place for all scorecards. PI information is on agenda to discuss at every Quality council meeting.	1. Quality council will monitor data monthly through our QAPI program and report quarterly to Governing Board. Aggregated data that is collected will be measured to ensure benchmarks are reached of 90% or greater. If benchmarks are not made a new action plan will be made or modified and reassess their effectiveness after 90 days.	Sample size will vary as it will come from the amount of incident reports related to patient safety (medication errors, patient injuries etc.)	Numerator: # of noncompliant items Denominator: # of sample size (charts or designated action)	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director. Items noncompliant for 3 consecutive months will be scored on prioritization grid for PI or task group implementation. PI or task group data will be reviewed monthly by quality and quarterly in BOG.	Heather Hernandez, Director of Quality	11/1/19
6	L495	322.040.81 ADMIN RULES-PERFORM EVALS	2. The facility's quality program will include aggregated data from pharmacy, therapy, nursing, EOC, UR, HIM and other areas of hospital for the Quality Committee to analyze trends and determine if any process improvement is needed and ensure benchmarks have been reached.	2. Quality Director will collect monthly data from leadership members; Quality council will analysis data and determine appropriate action plans are in place for all scorecards. PI information is on agenda to discuss at every Quality council meeting. All leadership and department heads will be involved in establishing the QAPI program from their respective areas. During next Quality Improvement Committee leadership staff will be educated on policy #6366314 "Organizational Quality Improvement Plan" and how the QAPI collects and analyzes aggregated data to measured to ensure benchmarks are reached; evaluate the effectiveness of actions taken or modify processes and reassess their effectiveness.	2. Quality council will monitor data monthly through our QAPI program. Aggregated data that is collected will be measured to ensure benchmarks are reached of 90% or greater. If benchmarks are not made a new action plan will be made or modified and reassess their effectiveness after 90 days. Quality council has PI overview on agenda and will go over PI that fall out of compliance or has not reached benchmarks.	Sample size will include a 10 chart review of selected indicators. All departments will have a minimum of 4 indicators to include required and problematic measures	Numerator: # of noncompliant items Denominator: # of sample size (charts or designated action)	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director. Items noncompliant for 3 consecutive months will be scored on prioritization grid for PI or task group implementation. PI or task group data will be reviewed monthly by quality and quarterly in BOG.	Heather Hernandez, Director of Quality	11/1/19
6	L495	322.040.81 ADMIN RULES-PERFORM EVALS	3. The Director of Quality with the Quality Improvement Committee will develop, monitor and implement performance improvement measures for patient safety and quality of care and create action plans needed to address concerns. Meeting minuets will be more robust and include aggregated data that was analyzed and measured.	3. Quality Director will collect monthly data from leadership members; Quality council will analysis data and determine appropriate action plans are in place for all scorecards. PI information is on agenda to discuss at every Quality council meeting. The Quality Improvement Committee leadership staff will be educated on policy #6366314 "Organizational Quality Improvement Plan" and how the QAPI collects and analyzes aggregated data to measured to ensure benchmarks are reached; evaluate the effectiveness of actions taken or modify processes and reassess their effectiveness.	3. Quality council will monitor data monthly through our QAPI program. Aggregated data that is collected will be measured to ensure benchmarks are reached of 90% or greater. If benchmarks are not made a new action plan will be made or modified and reassess their effectiveness after 90 days. Quality council has PI overview on agenda and will go over PI that fall out of compliance or has not reached benchmarks.	Sample size will include a 10 chart review of selected indicators. All departments will have a minimum of 4 indicators to include required and problematic measures	Numerator: # of noncompliant items Denominator: # of sample size (charts or designated action)	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director. Items noncompliant for 3 consecutive months will be scored on prioritization grid for PI or task group implementation. PI or task group data will be reviewed monthly by quality and quarterly in BOG.	Heather Hernandez, Director of Quality	11/1/19

Rainier Springs DOH Plan of Correction
Survey Completed on 10/1/19

	DOH	Standard Cited	Action Plan and prevention of recurrence	Process (Education/Training)	Monitoring and Tracking	Sample Size	Audit	Target for Compliance	Out of Compliance Follow up	Responsible Person	Date
6	L495	322.040.81 ADMIN RULES-PERFORM EVALS	4. The facility's quality program is implemented and will include aggregated data regarding all departments and individuals with clinical privileges including those with contracted services; such as, Medication Management, Pharmacy and Safety Management, Risk Management, Infection Control, Utilization Management, Clinical Laboratory Services, Nursing Services, Nutritional Services, Pharmacy Services, Therapeutic and Discharge Planning and analyze trends and determine if any process improvement is needed and ensure benchmarks have been reached. 100% of all contracts are updated, have their annual or quarterly evaluations completed using Rainier Springs annual review form and will be reviewed and approved by Governing Body at next Governing Board December 3rd.	4. Quality Director will collect monthly data from leadership members; Quality council will analysis data and determine appropriate action plans are in place for all scorecards. PI information is on agenda to discuss at every Quality council meeting. CEO, Director of Quality, Director of Nursing and Director of Clinical Services will complete annual evaluations for all clinical contracts. During next Governing Board December 3rd.	4. Quality council will monitor data monthly through our QAPI program. Aggregated data that is collected will be measured to ensure benchmarks are reached of 90% or greater. If benchmarks are not made a new action plan will be made or modified and reassess their effectiveness after 90 days. Quality council has PI overview on agenda and will go over PI that fall out of compliance or has not reached benchmarks. Lindsey Wee, Administrative Assistant will monitor when clinical contracts are due monthly and ensure the appropriate leadership member conducts annual review	Sample size will include a 10 chart review of selected indicators. All departments will have a minimum of 4 indicators to include required and problematic measures	Numerator: # of noncompliant items Denominator: # of sample size (charts or designated action)	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director. Items noncompliant for 3 consecutive months will be scored on prioritization grid for PI or task group implementation. PI or task group data will be reviewed monthly by quality and quarterly in BOG.	Heather Hernandez, Director of Quality	11/1/19
7	L505	322.050.1A PROVIDE PATIENT SERVICES	Director of Clinical Services is hiring more staff to adequately provide mental health therapy treatment. Interviews are being conducted to fill any open positions. Director of Clinical Services will report to Governing Board compliance with approved hospital staffing model. Therapy staff will provide groups and will be provided by trained staff.	Director of Clinical Services will meet with therapists daily for next 4 months to ensure they are able to provide 100% of groups for the next day per regulations. If staffing is inadequate for the next day, Director of Clinical services will call per-diem staff to provide groups or the Director of Clinical Services can provide groups. Director of Clinical Services will meet with HR monthly to review any open positions.	1. 100% of groups will be monitored to ensure groups occur with appropriate staff. 2. Provision of care and staffing model will be reviewed annually.	100% of groups will be provided.	Numerator: Groups provided Denominator: 12 Groups (4 per unit) Numerator: # of staff Denominator: # of appropriate staff	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Rebecca Bradley Director of Clinical Services	11/1/19
8	L520	322.050.2 JOB DESCRIPTIONS	Discharge planning details have been added to Therapist job description.	All therapists will sign new job description which includes new job details.	100% of all therapists shall sign new job description. An audit of all therapist who signed new job description will be conducted.	100%	# of therapist with revised job description/# of therapist	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by HR director.	Andrea Chepkwony, Manager of HR	11/1/19
9	L530	322.050.4 WORK REFERENCES	HR will ensure that work references are contacted prior to starting employment.	HR manager will be educated to contact new employees references prior to starting employment	100% of new employees will be audited by HR for work references for the next 120 days.	100%	# of new hire references contacted/# of new hires	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by HR director.	Andrea Chepkwony, Manager of HR	10/28/19
10	L545	322.050.6A ORIENTATION-ORG	HR will ensure that all contracted workers will be completed orientation prior to starting employment.	HR manager will be educated on having contracted workers complete orientation prior to start of employment.	Contracted employees will be audited by HR for orientation attendance for the next 120 days.	100%	# of contract employees completing orientation/# of contract new hires	90%		Andrea Chepkwony, Manager of HR	10/28/19
11	L675	322.060.1 HIV/AIDS TRAINING	HR will ensure that employees that require HIV/AIDs training will have the training within 30 days of employment.	HR manager will be educated to have all new employees which require HIV/AIDs training complete their training as needed.	100% of new employees which require HIV/AIDs training will be audited by HR for HIV/AIDS training for the next 120 days.	100%	# of new hires completing HIV/AIDS training/# of new hires	90% or greater		Andrea Chepkwony, Manager of HR	10/28/19
12	L810	322.120.6B WATER TEMPERATURE	Water temperature will be set to 120	EOC manager changed temperature at time of survey	EOC manager to take temperature of water 1x week for next 120 days		Compliant water temperature checks/# of times water temperature checked	90% or greater		Cole Johnson, EOC Manager	11/20/19
13	L1065	322.170.2E TREATMENT PLAN-COMPREHENS	Treatment plans will be individualized, define problems, have new problems added as needed, and document course of treatment including discharge plan.	Clinical staff will be re-educated on treatment plan process including adding new problems to the treatment plan and documenting the course of treatment.	Director of Clinical Services will audit 21 charts Monday through Friday to ensure documentation is appropriate.	21 charts daily	Numerator: Treatment plan compliance (course of tx, individualized, new problems added) Denominator: 21charts	90% or greater	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Rebecca Bradley Director of Clinical Services	11/1/19
14	L1150	322.180.1D PHYSICIAN AUTHORIZATIO N	1. House Supervisor will audit all Restraint/ Seclusion paperwork to ensure there is a complete provider order and that all T/O's will be signed within 48 hours of providing restraint/seclusion order.	1. Providers will be educated on seclusion and restraint orders and their indications for minimum or maximum time allowed. Form change is being assessed and will be sent for approval.	Director of Nursing to audit 100% of restraint/seclusion paperwork/orders as they happen to ensure proper documentation and complete provider orders. Results will be reported out in quality monthly for 4 months.	100%	Numerator: Total # of restraint and/or seclusion incidents with compliant documentation Denominator: Total # of restraints incidents	90% or greater		Caroline Rath, Director of Nursing	10/28/19
14	L1150	322.180.1D PHYSICIAN AUTHORIZATIO N	2. House Supervisor will audit all Restraint/ Seclusion paperwork to ensure there is a complete provider order and that all T/O's will be signed within 48 hours of providing restraint/seclusion order.	2. Providers will be educated on how to write appropriate orders for seclusion and restraint which will include inappropriate needs for seclusion such as "as needed" or "for agitation". Education to be completed on process 10/28/19.	Director of Nursing to audit 100% of restraint/seclusion paperwork/orders to ensure proper documentation and complete provider orders. Results will be reported out in quality monthly for 4 months.	100%	Numerator: Total # of restraint and/or seclusion incidents with compliant documentation Denominator: Total # of restraints incidents	90% or greater		Caroline Rath, Director of Nursing	10/28/19
15	L1360	322.210.2 PHARMACY-APPROVAL	Pharmacist will supervise pharmacy tech duties including but not limited to unit dosing of bulk medications in the main pharmacy. Pharmacy will implement barcode scanning when new PIC comes on	Oversight and education/training to new pharmacy tech when after AUP is approved. On-boarding to include ADDD policies on checking medications prior to distribution to an ADDD. All meds will go through pharmacist verification process. Pharmacy will implement barcode scanning when new PIC comes on.	Pharmacist will sign Pyxis refill sheet and keep on file in pharmacy to show pharmacist reviewed medication after repacking by pharmacy tech. Pharmacist performs random audit of pharmacy tech duties/process 3x weekly for next 4 months to ensure accuracy.	3x week	Numerator: Accuracy of Pharmacy tech repacking Denominator: 3x weekly monitoring. Numerator: Pharmacy preformed audit Denominator: 3x week	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19

Rainier Springs DOH Plan of Correction
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	DOH	Standard Cited	Action Plan and prevention of recurrence	Process (Education/Training)	Monitoring and Tracking	Sample Size	Audit	Target for Compliance	Out of Compliance Follow up	Responsible Person	Date
16	L1365	322.210.3A PROCEDURES-MED AUTH	1. IPS Director of Pharmacy Kyle Yoder audited all discrepancies of controls in pharmacy and corrected (all accounting errors). Pharmacist and IPS Director of Pharmacy conducted a pharmacy inventory of 100% of current inventory. Inventories will be conducted monthly by pharmacist and DON or IPS Director of Pharmacy, then quarterly with DON or IPS Director of Pharmacy. All controlled substance listed in schedule I and II are recorded in a separate inventory than scheduled III, IV and V. There are 2 binders with separate inventories, titled I and II, and the other binder titled III, IV and V. Inventories will be kept for at least 2 years. A standard template is used for conducting the inventory. The finalized inventory report will be provided to P&T every 6 months to ensure completion.	1. IPS Pharmacy will perform a monthly inventory for 4 months then quarterly. The finalized inventory report will be provided to P&T every 6 months to ensure completion.	1. IPS Pharmacy will perform a controlled substance inventory weekly for 4 months then quarterly. The finalized inventory report will be provided to quarterly P&T for next 6 months to ensure completion.	1 inventory per week	Numerator: completed inventory Denominator: 1 inventory per wk.	100% inventory completed	Failure to complete audit will be reviewed in quality council and a documented plan of action for improvement will be completed.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
16	L1365	322.210.3A PROCEDURES-MED AUTH	2. Policy # 6069616 "Controlled Substance Administration and Record Keeping" updated 10/2019 states that; "if a discrepancy is noted, the nurse investigates the discrepancy and resolves the discrepancy in the Pyxis system, if appropriate. (a) Two nurses are required to resolve the medication discrepancy in the Pyxis. (b) if a discrepancy cannot be resolved within 24 hours, the nurse fills out a Medication Variance Report and reports discrepancy to DON and Pharmacy for proper investigation." It also states "At any time, if a diversion is suspected, the nurse manager and DON are notified immediately. At that time, no nurse is to leave the premise until permitted by nursing leadership."	2. Education on policy #6069616 "Controlled Substance Administration and Record Keeping" to nursing staff on 10/14. A Discrepancy log was created. Education on diversion process as well which is indicated in policy #6069616. "	2. DON will monitor discrepancy audits daily for the next 4 months.	1 Audit per unit for total of 3.	Numerator: Compliant with clearing discrepancies Denominator: 3 unit audits	100% discrepancies cleared	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
16	L1365	322.210.3A PROCEDURES-MED AUTH	3. Pharmacy in charge will maintain adequate records of controlled substances Rainier Springs Policy (Drug Diversion 7141268) was created.	3. A weekly controlled substances inventory will be conducted and records will be maintained in the pharmacy.	1. IPS Pharmacy will perform a controlled substance inventory weekly for 4 months then quarterly. The finalized inventory report will be provided to quarterly P&T for next 6 months to ensure completion.	1 inventory per week	Numerator: completed inventory Denominator: 1 inventory per wk.	100% inventory completed	Failure to complete audit will be reviewed in quality council and a documented plan of action for improvement will be completed.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
16	L1365	322.210.3A PROCEDURES-MED AUTH	4. Nurses will perform blind counts and investigate and clear discrepancies per Rainier Springs Policy "Drug Diversion" 7141268. Also 2 nurses will conduct a full controlled medication inventory and document on the inventory record per policy "Controlled Substance Administration and Record Keeping".	4. Education to nursing staff and pharmacist on both policies "Controlled Substance Administration and Record Keeping" and "Drug Diversion"	4. DON/House Supervisor will conduct a daily audit of 1 patient per unit for the first 4 months, then move to 10 patients monthly, followed by periodic monitoring. The audit will compare legend and narcotic administration against MAR documentation and any discrepancies will be reported to the DON immediately. Weekly RN controlled substance Pyxis inventory are documented weekly on the med room checks - audited by DON/RN Sup	3 patients daily	Numerator: legend/narcotic admin Pyxis vs MAR compliance Denominator: 3 patients daily Weekly controlled substance Pyxis inventory conducted.	100%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
16	L1365	322.210.3A PROCEDURES-MED AUTH	5. IPS or the pharmacist will be available to lead P&T Committees and participate in QAPI Council, and quarterly to MEC and report out required aggregated data including medication variances. P&T Committee monitors, assesses and evaluate patient care and quality control actives of pharmacy services including medication use, storage and distribution of safe use which includes medication variances.	5. IPS or the pharmacist will be educated on need to be available to lead P&T Committees and participate in QAPI Council, and quarterly to MEC. IPS/Pharmacist will report aggregated data monthly to P&T, QAPI Council, quarterly to MEC and Governing Board. Pharmacy will ensure that all agenda items will be discussed at P&T including quality control actives of pharmacy services; medication use, storage and distribution of safe use which includes medication variances.	5. P&T and Quality council will monitor aggregated data that is collected by pharmacy and will be measured to ensure benchmarks are reached of 90% or greater. If benchmarks are not made a new action plan will be made or modified and reassess their effectiveness after 90 days.	Varies based on data collected.	Numerator: # of noncompliant items Denominator: # of sample size (charts or designated action)	90%	Noncompliant items will be reviewed in P&T and quality with a documented plan of action for improvement. Data will also be reviewed monthly by quality and quarterly in BOG.	Megan Wildman, IPS Director of Pharmacy Implementation	1. 11/1
17	L1370	322.210.3B PROCEDURES ORDERS	Proper medication orders will be preformed by providers and by RNs taking orders including telephone orders. Orders shall include medication name, dose, route, frequency, indication or dx and date and time of order.	Education to providers at MEC and nursing staff on Policy #6069728 "Provider Order Guidelines"; orders to include: medication name, dose, route, frequency, indication or dx and date and time of order.	Pharmacy will print any orders requiring invervention daily. If intervention is needed, Pharamcy will call unit and follow up with DON. Pharamcy will provide DON with a weekly report	100%	Numerator: Clincial interventions Denominator: # of orders	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	11/8/19

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18	L1375	322.210.3C PROCEDURES ADMINISTER MEDS	IPS Director of Pharmacy audited all medication in Pyxis and ensured doses are at appropriate levels to prevent excessive overrides due to inadequate doses. During P&T meeting on 10/22; override medication list was approved. "Obtaining Medications When the Pharmacy is Closed/Overrides" PolicyStat ID 7140924 has been reviewed and approved by the Governing Board. The includes the criteria for selection of medications and the current approved medication list 10/22. P&T approved override list. This new approved override list matches Pyxis and is posted in pharmacy. Rainier Springs Policy "Drug Diversion" policy was developed as well (#7141268.)	Policies and procedures were developed and reviewed approved by Governing Board. Pyxis will be updated with any new approved override medications. The pharmacy competency checklist was updated to include reconciling of overrides for accuracy and cross-reference with override list & ability to update medication override status in Pyxis database. Pharmacy staff has been given new competencies.	Pharmacist will provide DON a weekly override medication report for 4 months. Override report will be compared to the approved override list to ensure the override list matches what has been removed from the Pyxis.	1 weekly override list.	Numerator: Overrides from Pyxis Denominator: Overrides from approved list	90% of overrides to be on the approved list	Analyze any patterns or consistent medications being pulled not on the approved override list and determine through P&T if they need to be added to the approved override list.	Megan Wildman, IPS Director of Pharmacy Implementation	10/22/19
19	L1390	322.210.3F PROCEDURES-AUTHENTICATE	Providers will authenticate all orders w/in guidelines and policy of 48 hours.	Re-education to providers that orders need to be authenticated w/in 48 hours. Nurses will flag all orders that need authenticated from the previous day. During treatment team meetings providers will authenticate orders as needed.	Nursing staff will audit 10 charts daily for the next 4 months to ensure telephone orders were authenticated.	10 charts daily	Numerator: telephone orders authenticated Denominator: 10 telephone orders	90%	Telephone orders that fall out of compliance will be authenticated in real time. If there is a pattern of not meeting target of 90% it will be reviewed in quality with a documented plan of action for improvement by Medical Director	Caroline Rath Director of Nursing	11/8/19
20	L1395	322.210.3G PROCEDURES-USE OF MEDS	New process of : Pharmacist will affix a hospital pharmacy label to each bulk medication and each home medication which signifies the medication has been verified by a pharmacist and will include the pharmacist's handwritten initials and date on each label was memorialized in Policy# 7150436 4890035 "Administration of Own/Personal Medications" has been updated.	Education to pharmacist and nursing staff on Rainier Springs policy #6005602 Administration of Own/Personal Medications. This policy was updated 10/2019 and states "medications brought into the Facility by patients shall not be administered until a Pharmacist (1) identifies the medication, verifies integrity via visual inspection and (2) labels the medication including name, one other identifier, and patient location. Pharmacy shall also attach a supplemental label to the container to verify that the medication is approved for administration. The supplemental label must not obscure essential information on the original label."	100% of patients with home medications will be audited by pharmacy for next 6 months by using a step down process; If no deficiencies have been found for 30 days consecutively auditing will move to weekly, if no deficiencies have been found for 30 days auditing will move to monthly. If at any time deficiency is found re-education will be provided and audits will move back to daily auditing.	100% of home medications	Numerator: Home medications have been verified with label Denominator: # of home medications verified.	90%	Failure to complete verification and not label home medications will be reviewed in quality council and P&T and a documented plan of action for improvement will be completed.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
21	L1400	322.210.3H PROCED-MEDS IN PATIENT AREA	1. Pharmacist will conduct unit inspections of each unit on a monthly basis to ensure that a patient-owned medication are clearly labeled, verified, and within date. Pharmacist will affix a hospital pharmacy label to each bulk medication and each home medication which signifies the medication has been verified by a pharmacist and will include the pharmacist's handwritten initials and date on each label.	1. Pharmacist will conduct monthly unit inspections for each unit. Pharmacist will affix a hospital pharmacy label to each bulk medication and each home medication which signifies the medication has been verified by a pharmacist and will include the pharmacist's handwritten initials and date on each label.	1. Pharmacist will report monthly inspections to Quality council and quarterly to P&T. 100% of patients with home medications will be audited on a daily basis by nursing for next 4 months.	100% of home medications	Monthly unit inspections will be reviewed in P&T and Quality council. Numerator: Home medications have been verified with label Denominator: # of home medications verified.	90%	Failure to complete verification and not label home medications will be reviewed in quality council and P&T and a documented plan of action for improvement will be completed.	Megan Wildman, IPS Director of Pharmacy Implementation	10/22/19
21	L1400	322.210.3H PROCED-MEDS IN PATIENT AREA	2. Names on packaging will include "Generic for..." insert band name. All packaging in Pyxis will include the new labels with correct verbiage. All new medications have correct labeling with "Generic for" insert band name.	2. IPS will change out all labels on medications in Pyxis to include new verbiage and ensure all new medications will have appropriate labeling which includes new verbiage.	2. IPS/pharmacist will audit a sample of 100% of labels monthly for the next 4 months.	100%	Numerator: "generic for.." labels Denominator: # of labels	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	10/22/19
22	L1410	322.210.3J PROCEDURES-OUTDATED MEDS	Pharmacist will verify expiration dates on all medications and affix a beyond use date (BUD) label.	IPS to ensure new pharmacist is educated on verifying expiration dates on all mediations and labeling beyond use date on medications.	IPS/pharmacist will audit 10 labels a week for 4 months to ensure expiration dates are on labels.	10 labels weekly	Numerator: Expiration date present Denominator: 10 labels	90%	Noncompliant items will be reviewed in quality with a documented plan of action for improvement by responsible director.	Megan Wildman, IPS Director of Pharmacy Implementation	11/1/19
23	L1485	322.230.1 FOOD SERVICE REGS	All dietary staff will use proper hand hygiene techniques include changing gloves appropriately. When cooling foods the appropriate cooling pan will be used.	Infection Control Nurse will re-educate Dietary staff on proper hand hygiene. New cooling pans ordered with appropriate depths of 1 inch and will replace the current cooling pans.	2(a) Infection Control Nurse will audit and monitor hand hygiene in the dietary department (10x per month.) 2(b). Dietary Manager will monitor the use of appropriate cooling pans daily.	2(a) 10x per month 2(b) daily check on cooling pan use	Numerator: Compliance with hand hygiene technique Denominator: 10 overserved hand hygiene technique	90%	Noncompliant items will be reviewed in quality and in infection control committee with a documented plan of action for improvement by responsible director.	Debe Nagy-Nero, Director of Dietary Services	11/1/19
24	L1520	322.230.2G FOOD SERVICE MANUAL	An approved Therapeutic Diet Manual will be provided to Dietary Manager. The Diet Manual will have day, month and year.	A Therapeutic Diet Manual will be approved by dietician and providers. The Diet Manual will have date, month and year. The Therapeutic Diet Manual will go thought MEC for approval.	Director of Quality will have Dietary Manager sign off that she has received an approved Therapeutic Diet Manual		Therapeutic Diet Manual will be reviewed and approved annually by MEC	100%	Noncompliant will be reviewed in quality with a documented plan of action for improvement by responsible director.	Debe Nagy-Nero, Director of Dietary Services	11/1/19
25	L1525	322.230.2H FOOD SERVICE-MENU PLANNING	An approved Therapeutic Diet Manual will be provided to Dietary Manager. The Diet Manual will have day, month and year.	Dietary Manager will ensure menus are identified by day, month and year and will contain all foods, including snacks that contribute to patient nutrition. They will be a week at lease one week in advanced and posted in patient areas.	Dietary Manager will monitor that menus meet requirements and are posted in patient areas.	3 Units	Units with appropriate posted diets/# of units	90%	Noncompliant will be reviewed in quality with a documented plan of action for improvement by responsible director.	Debe Nagy-Nero, Director of Dietary Services	11/1/19

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26	L1565	322.240.4A LAUNDRY WATER TEMPERATURE	A booster will be used to ensure the washing machine temperature reaches 140 degrees.	EOC manger will contract a plumber to ensure our washing machines will reach 140 degrees.	EOC manager to take temperature of water 1x week for next 120 days upon fixing temperature.	3 machines	Washing machines with appropriate temperature /# of washing machines	90%	Noncompliant will be reviewed in quality with a documented plan of action for improvement by responsible director.	Cole Johnson, EOC Manager	11/20/19

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

December 3, 2019

Jeff Serrano, MC, MBA, CEO
Rainier Springs Behavioral Hospital
2805 NE 129th St.
Vancouver, WA 98686

Dear Mr. Serrano:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau completed a state private psychiatric hospital licensing survey at Rainier Springs Behavioral Hospital on October 1, 2019. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on December 3, 2019.

A Progress Report is due on or before December 30, 2019 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. I have included a sample Progress Report template as a separate attachment.

Please email this progress report to me at Lisa.Mahoney@doh.wa.gov.

Please contact me if you have any questions. I may be reached at 360-236-2972.

Sincerely,

Lisa Mahoney, MPH, HSC4
Survey Team Leader