State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: ______ B. WING ______	C 03/09/2023

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

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L 000	INITIAL COMMENTS . STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. Onsite dates: 02/28/23, 03/01/23, & 03/09/23 Case number: 2023-236 Intake number: 128197 The investigation was conducted by: Investigator #1 Investigator #2 There were violations found pertinent to this complaint. .	L 000	. 1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 04/03/23. 4. Email the ORIGINAL REPORT with the required signatures. .	
L 335	322-035.1G POLICIES-EMERGENCY CARE 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: (g) Emergency	L 335		

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medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment;
This Washington Administrative Code is not met as evidenced by:
Based on observation, interview, and document review, the hospital failed to implement policies and procedures, for the management of medical emergencies and transfers, to ensure staff completed and documented incident reports when medical emergencies occurred for 36 of 48 events (Item #1), completed and documented Memorandums of Transfer for 5 of 14 transferred patients (Patients #1, #2, #3, #4, and #5) (Item #2), and facilitated prompt access to Emergency Medical Services for 7 of 7 emergency responses reviewed (Patients #5, #7, #8, #9, #10, #11, and #12) (Item #3).

Failure to implement policies and procedures for the management of medical emergencies and transfers risks patient harm from delayed or unmet care needs.

Findings included:

Item #1 - Incident Reports

1. Document review of the hospital's policy titled "Incident Reports," policy #PI-003, effective 05/2019, last reviewed 01/2022, showed that the staff member who was involved or witnessed the event must complete an incident report form prior to the end of the shift. Report is forwarded to Performance Improvement (PI) Director and Chief Nursing Officer (CNO) by end of shift.

Document review of the hospital's policy titled

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"Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that in the event of a medical emergency, defined as an unexpected illness or injury, an incident report will be completed documenting details of any event.

Document review of the hospital's policy titled "Emergency Medical Screening," policy #PC 034, effective 04/2019, last reviewed 07/2020 showed the following:

a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings.

b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.

c. Staff will complete an incident report and route it to the PI Director.

2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacey Fire Department 911 (emergency) responses to the hospital between 12/02/22 and 03/02/23 and a hospital incident report log of all incident reports between 12/01/22 and 03/08/23. The review showed the following:

a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.

b. Of the 48 emergency responses to the hospital, 36 were missing corresponding hospital incident reports.

c. On 02/28/23 at 2:30 PM, Investigators #1 and #2 interviewed the Chief Nursing Office (CNO)

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(Staff #1101). Staff #1101 verified that current policy was to enter an incident report if 911 is called.

Item #2 - Memorandums of Transfer

1. Document review of the hospital's policy titled "Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that once a medical emergency has been addressed, a Memorandum of Transfer will be prepared and forwarded at the first available opportunity.

Document review of the hospital's policy titled "Memorandum of Transfer," policy ID RT-017, effective date 05/2019, last reviewed 01/2022, showed the following:

a. A Memorandum of Transfer will be completed on all patients transferred outside the hospital's facilities.

b. Memorandum of Transfer must be completed for every patient transferred and must contain the following information: patient data, a certification signed by the transferring physician, type of vehicle and company used for transfer, and name and city of hospital to which patient was transported.

c. A copy of the Memorandum of Transfer shall be retained by the transferring and receiving hospitals.

Patient #1

2. On 02/28/23 at 2:00 PM, Investigators #1 and #2, the Director of Admissions and Referrals (Staff #1104) and a Nurse Manager (Staff #1105) reviewed the Memorandum of Transfer (MOT) file

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for the month of 02/23. The review showed the following:

a. On 02/27/23, Patient #1 presented to intake with an infected wound to the right forearm. Patient #1 was transported to another facility by ambulance at 12:45 PM and an MOT was retained in the file.

b. Review of the MOT showed that no accepting facility was documented on the form.

c. Staff #1104 confirmed the investigators finding of the missing documentation.

Patient #2

3. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following:

a. On 02/26/23, Patient #2 presented to intake after a suicide attempt and refused to be a voluntary admission. Patient #2 was transported to another facility by ambulance at 3:18 PM and an MOT was retained in the file.

b. Review of the MOT showed that no physician certification signature was documented on the form.

c. Staff #1104 confirmed the investigators finding of the missing documentation.

Patient #3

4. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review

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showed the following:

a. On 02/28/23, Patient #3 presented to intake requesting alcohol detoxification and was found to have an elevated blood pressure and heart rate. Patient #3 was transported to another facility at an unknown time and an MOT was retained in the file.

b. Review of the MOT showed that no physician certification signature, no accepting facility, no mode of transport, and no patient consent signature were documented on the form.

c. Staff #1104 confirmed the investigators findings of the missing documentation.

Patient #4

5. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following:

a. On 02/27/23, Patient #4 presented to intake requested admission for suicidal ideation and was found to be dependent on a caregiver for bathroom and showering needs. Patient #4 was transported to an unknown facility at an unknown time.

b. The investigators were unable to locate an MOT for Patient #4.

C. Staff #1104 confirmed the investigators finding of the missing MOT.

Patient #5

6. On 02/28/23 at 3:00 PM, Investigators #1 and

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#2 reviewed the medical record of Patient #5, a non-verbal admitted patient with major depressive disorder and suicidal ideation. The review showed the following:

a. On 12/23/22 at 8:30 AM, Patient #5 had an unwitnessed fall and 911 was called to transport the patient to a local hospital for evaluation and treatment.

b. The investigators were unable to locate an MOT for Patient #5.

7. On 02/28/23 at 2:30, Investigators #1 and #2 interviewed Staff #1101. The interview showed that an MOT should be filled out completely for every patient transported out of the hospital.

Item #3 - Access to Emergency Medical Services

1. Document review of the hospital's policy titled "Memorandum of Transfer," policy ID RT-017, effective date 05/2019, last reviewed 01/2022, showed that for all patients with an emergency medical condition that the hospital does not have the appropriate equipment or staff to correct, an evaluation and treatment shall be performed, and transfer shall be carried out as quickly as possible.

Document review of the hospital's procedure titled "South Sound Behavioral 9-1-1 EMS Response," no policy ID, no date, showed the following:

a. When 911 is called, nursing staff will notify intake that Emergency Medical Services (EMS) have been dispatched and where the patient is located while the team prepares a staff escort.

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b. Intake staff should be ready at the door to greet Lacey Fire Crews and provide a staff escort throughout the locked-in facility the whole time.

c. If the patient is ambulatory/conscious, they are to be brought to the first floor (exercise room) for patient privacy and safety of patients and 911 crews.

d. If a unit floor response is necessary, escort Lacey Fire Crews to appropriate unit and ask that other patients do not wander around 911 crews. Patients should be held off either in their room or common area; whichever is furthest from Lacey Fire Crews.

e. A nurse should be available to describe why a 911 response was necessary and to communicate with Lacey Fire Crews.

f. Staff escort (nursing) should stay with Lacey Fire from beginning to end of call.

Emergency Response #1

2. On 02/22/23, Investigators #1 and #2 reviewed call records and recordings from Thurston 911 Communications (TCOMM 911). The review showed that on 12/09/22 at 5:36 PM, hospital staff called 911 for Patient #7, a minimally responsive patient that had a blood glucose reading of 51 before receiving IM glucagon (a medication given to increase a person's blood glucose levels) and appeared sweaty. The hospital staff member stated that Patient #7 was located in unit 320-B three times, with repeat-back confirmation, during the 911 call.

a. On 02/21/23, Investigators #1 and #2 reviewed incident reports provided by Lacey Fire

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L 335	Continued From page 8 Department personnel. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient. c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed a staff nurse (Staff #1113). Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #2 3. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and	L 335		

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recordings from TCOMM 911. The review showed that on 12/23/22 at 8:48 AM, EMS were dispatched to a 911 call from the hospital for Patient #5, a non-verbal admitted patient with major depressive disorder and suicidal ideation who had an unwitnessed fall.

a. Lacey Fire Department Incident Reports showed that EMS reported waiting 5 minutes before gaining access to Patient #5 for evaluation. Patient #5 had no obvious injuries and was transported to a local Emergency Department (ED) for evaluation at hospital staff's request.

b. On 02/28/23 at 5:15 PM, Investigator #1 interviewed an EMS staff member (Staff #1109). Staff #1109 confirmed that they had responded to the 911 call at the hospital on 12/23/22 at 8:48 AM. Staff #1109 stated that they were left alone and locked in the gym to wait for Patient #5 for 5 minutes.

c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.

d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

Emergency Response #3

4. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey

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Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 12/31/22 at 6:20 PM, EMS were dispatched to a 911 call from the hospital for Patient #8, a patient who was suffering from drug withdrawal and decreased level of consciousness.

a. Lacey Fire Department Incident Reports showed that EMS reported ringing the doorbell and waiting outside the hospital for 4 minutes before a hospital staff member let them in. EMS reported that they waited another 4 minutes for hospital staff to escort them to Patient #8 (who was waiting in a wheelchair) in B-322, a delay of 8 minutes.

b. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #8. The record showed that EMS arrived at the hospital at 6:31 PM and waited 4 minutes before gaining access to the facility, then waited another 4 minutes before gaining access to Patient #8, who had normal vital signs, had vomited and was shaking. Patient #8 was later transported to the ED via non-emergent ambulance transport.

c. On 02/24/23 at 11:13 PM, Investigator #1 interviewed an EMS staff member (Staff #1111) who responded to the 911 call for Patient #8. Staff #1111 stated that they often wait 5 to 12 minutes before gaining access to patients at the hospital.

d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.

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e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

Emergency Response #4

5. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 01/15/23 at 9:41 AM, EMS were dispatched to a 911 call from the hospital for Patient #9, a 63 year-old patient with a diagnosis of pneumonia (an infection in the lungs), a low oxygen saturation (a measure of how much oxygen is traveling through the body), and a history of chronic obstructive pulmonary disease (a chronic inflammatory disease that obstructs airflow from the lungs).

a. Lacey Fire Department Incident Reports showed that EMS stated that they rang the doorbell twice and waited 4 minutes before gaining entry to the hospital.

b. On 03/01/23 at 11:53 AM, Investigators #1 and #2 reviewed hospital security footage of the emergency response to Patient #9 with the former Chief of Nursing (Staff #1106). The review showed the following:

i. At 9:46 AM, the EMS ambulance was seen pulling into the ambulance entrance.

ii. At 9:47 AM, EMS were seen knocking on the hospital entrance door.

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L 335	Continued From page 12 iii. At 9:50 AM, EMS were seen ringing the doorbell at the hospital entrance door, which was then opened, and EMS are then seen walking towards another door several feet away. iv. At 9:51 AM, EMS are seen entering the facility. c. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #9. The record showed that EMS arrived at the hospital at 9:47 AM, waited for entry to the facility, then waited for a hospital staff member who knew where Patient #9 was located. The record showed that EMS gained access to Patient #9 at 9:55 AM to evaluate and treat, a delay of 8 minutes. d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #5 6. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings provided by TCOMM 911. The review showed that on 02/11/23 at 11:06 PM, a non-emergent ambulance crew contacted Lacey Fire crews over their radio to inform that they were asked by hospital staff to evaluate Patient	L 335		

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#10 for respiratory distress. The non-emergent ambulance crew was unable to be reached over radio for further information, and Lacey Fire Crew dispatched to the hospital.

a. On 02/28/23 at 5:41 PM, Investigator #1 interviewed an EMS staff member (Staff #1112) who responded to the radio call for Patient #10. Staff #1112 stated that when they arrived at the hospital, the non-emergent crew informed them that they were unable to get a signal on their radio equipment to inform Lacey Fire Crews that they did not need their assistance, after they had assessed Patient #10.

b. On 03/01/23 at 11:53 AM, Investigators #1 and #2 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #10. The review showed the following:

i. At 10:49 PM, the non-emergency ambulance crew arrived at the facility.

ii. At 10:52 PM, the crew were seen ringing the facility doorbell.

iii. At 10:56 PM, the door was opened by a hospital staff member who has a short conversation with the crew.

iv. At 10:58 PM, the crew were left alone in the hallway and were seen using their radio to contact Lacey Fire Crews.

v. Between 10:58 PM and 11:03 PM, the crew were observed walking to different doors in the hallway and knocking on the door the hospital staff member had gone through.

vi. At 11:03 PM, a hospital staff member rejoins

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: ___ B. WING ___	C 03/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 335	Continued From page 14	L 335		

the crew and escorts them through a door.

vii. At 11:12 PM, Lacey Fire Crews were seen arriving at the hospital.

c. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #10. The record showed that the non-emergent ambulance crew arrived on scene for a patient who no longer required transport and were then asked to assess Patient #10, who had a low oxygen saturation. Patient #10 was assessed and found to have normal vital signs and to be speaking in full sentences.

d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.

e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

Emergency Response #6

7. On 03/10/23, Investigator #1 reviewed call logs and incident reports provided by Lacey Fire Department and call records and recordings provided by TCOMM 911. The review showed that on 02/15/23 at 1:40 PM, EMS were dispatched to a 911 call for Patient #11, a 34-year-old experiencing chest pain.

a. Review of the 9-1-1 recording showed that Patient #11 called 9-1-1 requesting assistance for

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: ____ B. WING ____	C 03/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 335	Continued From page 15	L 335		

chest pain. Patient #11 is heard asking hospital staff for the address and telephone number of the hospital. Dispatch personnel are heard confirming with Patient #11 that hospital staff are aware she is calling 9-1-1 for assistance.

b. On 03/09/23 at 11:48 AM, Investigator #1 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #11. The review showed the following:

i. At 1:46 PM, the EMS crew arrived at the hospital.

ii. At 1:47 PM, the EMS crew were seen knocking at the hospital entrance door.

iii. At 1:49:30 PM, after a delay of 2.5 minutes, hospital staff were seen opening the hospital door.

c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.

d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

Emergency Response #7

8. On 03/10/23, Investigator #1 reviewed call logs, incident reports, and Patient Care Records provided by Lacey Fire Department and call records and recordings provided by TCOMM 911.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013319	A. BUILDING: ______ B. WING ______	C 03/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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The review showed that on 02/25/23 at 11:35 PM, EMS were dispatched to a 911 call from the hospital for Patient #12, a 38-year-old experiencing drug withdrawal symptoms with a history of stroke and seizures.

a. On 03/09/23 at 11:48 AM, Investigator #1 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #12. The review showed the following:

i. At 11:43 PM, the EMS crew were seen ringing the doorbell at the hospital entrance door.

ii. At 11:46 PM, after a delay of 3 minutes, hospital staff were seen opening the hospital door.

b. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.

c. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

Reviewed & approved
4/4/23

South Sound Behavioral Hospital
Plan of Correction for
Department of Health Survey
Date on Site- 2/28/23, 3/01/2023 &3/09/2023
Case Number: 2023-236

Statement of Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
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: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to implement policies and procedures, for the management of medical emergencies and transfers, to ensure staff completed and documented incident reports when medical emergencies occurred for 36 of 48 events (Item #1), completed and documented Memorandums of Transfer for 5 of 14 transferred patients (Patients #1, #2, #3, #4, and #5) (Item #2), and facilitated prompt access to Emergency Medical Services for 7 of 7 emergency responses reviewed (Patients #5, #7, #8, #9, #10, #11, and #12) (Item #3). Failure to implement policies and procedures for the management of medical emergencies and transfers risks patient harm from delayed or unmet care needs. Findings included:	South Sound Behavioral Hospital (SSBH) is now in compliance with the Medicare Conditions of Participation as described in 42 CFR 482. SSBH protects the health and safety of the patients, staff and others. The Governing Board called a special meeting on 3/2/2023. The findings from the initial WA state survey were discussed. The policies and procedures were reviewed and determined to be appropriate. The breakdown in the hospital's lack of compliance was discussed. The hospital leadership committed to the Governing Board that the hospital staff will be reeducated and will be held responsible to perform their duties related to emergency services SSBH Chief Executive Officer (CEO) was held accountable to the Governing Board in developing the corrective action plan with help from his management team. The CEO presented the action plan in the Governing Board Meeting on 3/30/23. The CEO will be held accountable to the Governing Board to ensure that SSBH maintains the corrective actions and complies with the Medicare Hospital Conditions of Participation. The Action Plan was adjusted to ensure that it addressed all of the concerns received in the	CEO	3/30/23	Approved Corrective Action Plan

Item #1 - Incident Reports 1. Document review of the hospital's policy titled "Incident Reports," policy #PI-003, effective 05/2019, last reviewed 01/2022, showed that the staff member who was involved or witnessed the event must complete an incident report form prior to the end of the shift. Report is forwarded to Performance Improvement (PI) Director and Chief Nursing Officer (CNO) by end of shift. Document review of the hospital's policy titled "Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that in the event of a medical emergency, defined as an unexpected illness or injury, an incident report will be completed documenting details of any event. Document review of the hospital's policy titled "Emergency Medical Screening," policy #PC 034, effective 04/2019, last reviewed 07/2020 showed the following: a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings. b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.	CMS letter dated 3/27/23.The Action Plan was reviewed in the Governing Board meeting held 3/30/23 at noon . The Governing Board reviewed, discussed and approved the action plan. The action plan will be monitored as described, reported to the PI Committee, and presented to the Governing Board on a minimum of a monthly basis until the hospital is 100% in compliance for 6 continuous months of providing consistent and timely access to emergency services. This is evidenced through completed documentation of incident reports when medical emergencies occur, completed Memorandum of Transfers (MOT) for transferred patients, and documentation of prompt access to Emergency Services in Code Blue documentation, and completion of New MOT Debrief/Review form . All emergency services occurring at SSBH are reported to the CEO/AOC ASAP by intake director and/or house supervisor. The PI Director /designee will review the Incident Report and all supporting documentation (example MOT/ Code Blue sheet, emergency call log, documentation) and reports this to the CEO. This is also recorded in the PI Dashboard. The Emergency Services response will be evaluated daily by the CNO/designee to ensure timely EMT entry, completion of New MOT Debrief/Review form completed by the nursing department that records SSBH response time to facilitate EMS access to the facility. For non-compliance the CNO/ designee will follow up promptly with the staff involved to review the process and provide documentation of the			

c. Staff will complete an incident report and route it to the PI Director.	follow up and re-education.			
2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacey Fire Department 911 (emergency) responses to the hospital between 12/02/22 and 03/02/23 and a hospital incident report log of all incident reports between 12/01/22 and 03/08/23. The review showed the following:	Governing Board approved new quality indicators consistent with monitoring timely response to emergency services and compliance of documentation required. The PI Director will report the results of the indicators in the monthly PI. The CEO will report the information to the Governing Board on a minimum of a monthly basis. The following are the new quality indicators.		**3/14/2023**	CEO Monthly Report to Governing Board
a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.	1. PI Director will ensure daily that log for all emergency call is complete. Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.	**PI Director**	**3/30/2023**	Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.
b. b. Of the 48 emergency responses to the hospital, 36 were missing corresponding hospital incident reports.	2. PI Director will ensure daily through nursing flash meetings that an incident report for every emergency call is completed. Compliance will be monitored with a 100% threshold for 6 consecutive months.	**PI Director**	**3/30/2023**	Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.
c. c. On 02/28/23 at 2:30 PM, Investigators #1 and #2 interviewed the Chief Nursing Office (CNO). (Staff #1101). Staff #1101 verified that current policy was to enter an incident report if 911 is called.	3. PI Director will ensure daily that fully completed MOT documentation for all emergency transfers are documented. Compliance will be monitored with a 100% threshold for 6 consecutive months.	**PI Director**	**3/30/2023**	Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.
Item #2 Memorandums of Transfer 1. Document review of the hospital's policy titled "Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that once a medical emergency has been addressed, a Memorandum of Transfer will be prepared and forwarded at the first available opportunity.	4. CNO/Intake Director/Designee will monitor SSBH response time to ensure timely EMT entry through New MOT Debrief/Review completed by nursing department daily in the nursing flash meeting and will be reported monthly in the committee of the whole. For non-compliance the PI Director/CNO/Intake Director will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education.	**CNO/ Intake Director**	**3/30/2023**	Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months. These indicators will be reported to governing board until 100% compliance is achieved for 6 consecutive months, then will monitor quarterly for sustained compliance.

Document review of the hospital's policy titled "Memorandum of Transfer," policy ID RT-017, effective date 05/2019, last reviewed 01/2022, showed the following: a. A Memorandum of Transfer will be completed on all patients transferred outside the hospital's facilities. b. Memorandum of Transfer must be completed for every patient transferred and must contain the following information: patient data, a certification signed by the transferring physician, type of vehicle and company used for transfer, and name and city of hospital to which patient was transported. c. A copy of the Memorandum of Transfer shall be retained by the transferring and receiving hospitals.	On 3/3/2023, an education series was implemented to train all current staff on the following: 1. Emergency medical services and promptness of escorting EMT to the site of emergency to ensure prompt access. 2. Filling out incident report and memorandum of transfer for all emergency calls. 3. Retraining of all staff on the policies and procedures when responding to medical emergencies. Evidence of training completion was documented through an attestation sheet. Staff and providers not completing education by 3/28/2023 have been removed from the schedule and will complete training before their next scheduled shift.	**All Department Heads**	**3/30/2023**	Attestation Signatures of All Staff.
Patient #1 2. On 02/28/23 at 2:00 PM, Investigators #1 and #2, the Director of Admissions and Referrals (Staff #1104) and a Nurse Manager (Staff #1105) reviewed the Memorandum of Transfer (MOT) file for the month of 02/23. The review showed the following: a. On 02/27/23, Patient #1 presented to intake with an infected wound to the right forearm. Patient #1 was transported to another facility by ambulance at 12:45 PM and an MOT was retained in the file. b. Review of the MOT showed that no accepting facility was documented on the form. c. Staff #1104 confirmed the investigators finding of the missing documentation.	On 3/3/2023, the new hire orientation material was updated to train all NEW staff on the following: 1. Emergency medical services and promptness of escorting EMT to the site of emergency to ensure prompt access. 2. Filling out incident report and memorandum of transfer for all emergency calls. 3. Policies and procedures when responding to medical emergencies. To further ensure improved emergency services, the following corrective action were implemented on 3/28/2023.	**PI Director and HR Director**	**3/30/2023**	Revised New Employee Orientation on Emergency Services
	1. New medical emergency flow chart was released and posted. This highlighted the process when responding to medical emergencies in the unit and in intake area. It also underscores that part of the process is filling out incident report and MOT (for medical transfers).	**CNO**	**3/30/2023**	Posted ion 3/30/2023
	2. New response team staffing assignment will	**CNO**	**3/328/2023**	

Patient #2 3. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following: a. On 02/26/23, Patient #2 presented to intake after a suicide attempt and refused to be a voluntary admission. Patient #2 was transported to another facility by ambulance at 3:18 PM and an MOT was retained in the file. b. Review of the MOT showed that no physician certification signature was documented on the form. c. Staff #1104 confirmed the investigators finding of the missing documentation. Patient #3 4. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following: a. On 02/28/23, Patient #3 presented to intake requesting alcohol detoxification and was found to have an elevated blood pressure and heart rate. Patient #3 was transported to another facility at an unknown time and an MOT was retained in the file. b. Review of the MOT showed that no physician certification signature, no accepting facility, no mode of transport, and no patient consent	clearly delegate escort to ensure dedicated person who will facilitate prompt access to the unit. This assignment sheet will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100% threshold. 3. MOT Debrief /Review was devised to track promptness of access to the unit. This MOT Debrief/Review will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100%. threshold. 4. A monthly hospital wide "Code Blue" Drill will be conducted by hospital leadership to ensure that staff are following policies and procedures. A "Code Blue" critique form will be submitted to the CNO for review. 4. Nursing flash agenda was revised on 3/28/2023 to reflect medical emergencies as an item to be reviewed with units. All data gathered will be presented by the CNO to the governing board monthly. For non-compliance the CNO/ designee will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education.	**CNO** **CNO**	**3/30/2023** **3/30/2023**	Daily audit. This assignment sheet will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100% threshold for 6 months. Daily audit. This assignment sheet will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100% threshold for 6 months. Monthly Drill and Code Blue Drill Documentation for 6 months. Daily Nursing Flash All data gathered will be presented by the CNO to the governing board monthly. Threshold will be 100% compliance for 6 months. For non-compliance the CNO/ designee will follow up promptly with the staff involved to review the process and provide documentation of the

signature were documented on the form. c. Staff #1104 confirmed the investigators findings of the missing documentation. Patient #4 5. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following: a. On 02/27/23, Patient #4 presented to intake requested admission for suicidal ideation and was found to be dependent on a caregiver for bathroom and showering needs. Patient #4 was transported to an unknown facility at an unknown time. b. The investigators were unable to locate an MOT for Patient #4. C. Staff #1104 confirmed the investigators finding of the missing MOT. Patient #5 6. On 02/28/23 at 3:00 PM, Investigators #1 and #2 reviewed the medical record of Patient #5, a non-verbal admitted patient with major depressive disorder and suicidal ideation. The review showed the following: a. On 12/23/22 at 8:30 AM, Patient #5 had an unwitnessed fall and 911 was called to transport the patient to a local hospital for evaluation and treatment.				follow up and re-education.

b. The investigators were unable to locate an MOT for Patient #5. 7. On 02/28/23 at 2:30, Investigators #1 and #2 interviewed Staff #1101. The interview showed that an MOT should be filled out completely for every patient transported out of the hospital. Item #3 - Access to Emergency Medical Services 1. Document review of the hospital's policy titled "Memorandum of Transfer," policy ID RT-017, effective date 05/2019, last reviewed 01/2022, showed that for all patients with an emergency medical condition that the hospital does not have the appropriate equipment or staff to correct, an evaluation and treatment shall be performed, and transfer shall be carried out as quickly as possible. Document review of the hospital's procedure titled "South Sound Behavioral 9-1-1 EMS Response," no policy ID, no date, showed the following: a. When 911 is called, nursing staff will notify intake that Emergency Medical Services (EMS) have been dispatched and where the patient is located while the team prepares a staff escort. b. Intake staff should be ready at the door to greet Lacey Fire Crews and				

provide a staff escort throughout the locked-in facility the whole time. c. If the patient is ambulatory/conscious, they are to be brought to the first floor (exercise room) for patient privacy and safety of patients and 911 crews. d. If a unit floor response is necessary, escort Lacey Fire Crews to appropriate unit and ask that other patients do not wander around 911 crews. Patients should be held off either in their room or common area; whichever is furthest from Lacey Fire Crews. e. A nurse should be available to describe why a 911 response was necessary and to communicate with Lacey Fire Crews. f. Staff escort (nursing) should stay with Lacey Fire from beginning to end of call. Emergency Response #1 2. On 02/22/23, Investigators #1 and #2 reviewed call records and recordings from Thurston 911 Communications (TCOMM 911). The review showed that on 12/09/22 at 5:36 PM, hospital staff called 911 for Patient #7, a minimally responsive patient that had a blood glucose reading of 51 before receiving IM glucagon (a medication given to increase a person's blood glucose levels) and appeared sweaty. The hospital staff member stated that Patient #7 was located in unit 320-B				

three times, with repeat-back confirmation, during the 911 call. a. On 02/21/23, Investigators #1 and #2 reviewed incident reports provided by Lacey Fire Department personnel. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient. c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed a staff nurse (Staff #1113). Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the				

patient was stable enough to get into a wheelchair. Emergency Response #2 3. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 12/23/22 at 8:48 AM, EMS were dispatched to a 911 call from the hospital for Patient #5, a non-verbal admitted patient with major depressive disorder and suicidal ideation who had an unwitnessed fall. a. Lacey Fire Department Incident Reports showed that EMS reported waiting 5 minutes before gaining access to Patient #5 for evaluation. Patient #5 had no obvious injuries and was transported to a local Emergency Department (ED) for evaluation at hospital staff's request. b. On 02/28/23 at 5:15 PM, Investigator #1 interviewed an EMS staff member (Staff #1109). Staff #1109 confirmed that they had responded to the 911 call at the hospital on 12/23/22 at 8:48 AM. Staff #1109 stated that they were left alone and locked in the gym to wait for Patient #5 for 5 minutes. c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait				

downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #3 4. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 12/31/22 at 6:20 PM, EMS were dispatched to a 911 call from the hospital for Patient #8, a patient who was suffering from drug withdrawal and decreased level of consciousness. a. Lacey Fire Department Incident Reports showed that EMS reported ringing the doorbell and waiting outside the hospital for 4 minutes before a hospital staff member let them in. EMS reported that they waited another 4 minutes for hospital staff to escort them to Patient #8 (who was waiting in a wheelchair) in B-322, a delay of 8 minutes. b. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #8. The record showed that EMS arrived at the hospital at 6:31 PM and waited 4 minutes before gaining access to the facility, then waited another 4 minutes				

before gaining access to Patient #8, who had normal vital signs, had vomited and was shaking. Patient #8 was later transported to the ED via non-emergent ambulance transport. c. On 02/24/23 at 11:13 PM, Investigator #1 interviewed an EMS staff member (Staff #1111) who responded to the 911 call for Patient #8. Staff #1111 stated that they often wait 5 to 12 minutes before gaining access to patients at the hospital. d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #4 5. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 01/15/23 at 9:41 AM, EMS were dispatched to a 911 call from the hospital for Patient #9, a 63 year-old patient with a diagnosis of pneumonia (an infection in the lungs), a				

low oxygen saturation (a measure of how much oxygen is traveling through the body), and a history of chronic obstructive pulmonary disease (a chronic inflammatory disease that obstructs airflow from the lungs). a. Lacey Fire Department Incident Reports showed that EMS stated that they rang the doorbell twice and waited 4 minutes before gaining entry to the hospital. b. On 03/01/23 at 11:53 AM, Investigators #1 and #2 reviewed hospital security footage of the emergency response to Patient #9 with the former Chief of Nursing (Staff #1106). The review showed the following: i. At 9:46 AM, the EMS ambulance was seen pulling into the ambulance entrance. ii. At 9:47 AM, EMS were seen knocking on the hospital entrance door. iii. At 9:50 AM, EMS were seen ringing the doorbell at the hospital entrance door, which was then opened, and EMS are then seen walking towards another door several feet away. iv. At 9:51 AM, EMS are seen entering the facility. c. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #9. The record showed that EMS arrived at the hospital at 9:47 AM, waited for entry to the facility, then waited for a hospital staff member who knew where Patient #9 was located. The				

record showed that EMS gained access to Patient #9 at 9:55 AM to evaluate and treat, a delay of 8 minutes. d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #5 6. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings provided by TCOMM 911. The review showed that on 02/11/23 at 11:06 PM, a non-emergent ambulance crew contacted Lacey Fire crews over their radio to inform that they were asked by hospital staff to evaluate Patient #10 for respiratory distress. The non-emergent ambulance crew was unable to be reached over radio for further information, and Lacey Fire Crew dispatched to the hospital. a. On 02/28/23 at 5:41 PM, Investigator #1 interviewed an EMS staff member				

(Staff #1112) who responded to the radio call for Patient #10. Staff #1112 stated that when they arrived at the hospital, the non-emergent crew informed them that they were unable to get a signal on their radio equipment to inform Lacey Fire Crews that they did not need their assistance, after they had assessed Patient #10. b. On 03/01/23 at 11:53 AM, Investigators #1 and #2 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #10. The review showed the following: i. At 10:49 PM, the non-emergency ambulance crew arrived at the facility. ii. At 10:52 PM, the crew were seen ringing the facility doorbell. iii. At 10:56 PM, the door was opened by a hospital staff member who has a short conversation with the crew. iv. At 10:58 PM, the crew were left alone in the hallway and were seen using their radio to contact Lacey Fire Crews. v. Between 10:58 PM and 11:03 PM, the crew were observed walking to different doors in the hallway and knocking on the door the hospital staff member had gone through. vi. At 11:03 PM, a hospital staff member rejoins the crew and escorts them through a door. vii. At 11:12 PM, Lacey Fire Crews were seen arriving at the hospital. c. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department				

Patient Care Record for Patient #10. The record showed that the non-emergent ambulance crew arrived on scene for a patient who no longer required transport and were then asked to assess Patient #10, who had a low oxygen saturation. Patient #10 was assessed and found to have normal vital signs and to be speaking in full sentences. d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #6 7. On 03/10/23, Investigator #1 reviewed call logs and incident reports provided by Lacey Fire Department and call records and recordings provided by TCOMM 911. The review showed that on 02/15/23 at 1:40 PM, EMS were dispatched to a 911 call for Patient #11, a 34-year-old experiencing chest pain. a. Review of the 9-1-1 recording showed that Patient #11 called 9-1-1 requesting assistance for chest pain.				

Patient #11 is heard asking hospital staff for the address and telephone number of the hospital. Dispatch personnel are heard confirming with Patient #11 that hospital staff are aware she is calling 9-1-1 for assistance. b. On 03/09/23 at 11:48 AM, Investigator #1 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #11. The review showed the following: i. At 1:46 PM, the EMS crew arrived at the hospital. ii. At 1:47 PM, the EMS crew were seen knocking at the hospital entrance door. iii. At 1:49:30 PM, after a delay of 2.5 minutes, hospital staff were seen opening the hospital door. c. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. d. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair. Emergency Response #7				

8. On 03/10/23, Investigator #1 reviewed call logs, incident reports, and Patient Care Records provided by Lacey Fire Department and call records and recordings provided by TCOMM 911. The review showed that on 02/25/23 at 11:35 PM, EMS were dispatched to a 911 call from the hospital for Patient #12, a 38-year-old experiencing drug withdrawal symptoms with a history of stroke and seizures. a. On 03/09/23 at 11:48 AM, Investigator #1 and Staff #1106 reviewed hospital security footage of the emergency response to Patient #12. The review showed the following: i. At 11:43 PM, the EMS crew were seen ringing the doorbell at the hospital entrance door. ii. At 11:46 PM, after a delay of 3 minutes, hospital staff were seen opening the hospital door. b. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS. c. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.				

Terrance J O'Reilly CEO Date

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

04/11/2023

TJ O'Reilly MBA, RN
South Sound Behavioral Hospital
605 Woodland Square Loop SE
Lacey, WA 98503

Re: Complaint #128197/2023-236

Dear Mr. O'Reilly,

Investigators from the Washington State Department of Health conducted a state hospital and Medicare hospital complaint investigation at South Sound Behavioral Hospital on 02/28/23, 03/01/23 and 03/09/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 04/11/23.

A Progress Report is due on or before 05/08/23 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. A sample progress report has been enclosed for reference.

Please send a scanned copy of this progress report to me at the following email addresses:

Starla.Tillinghast@doh.wa.gov and Sara.Nash@doh.wa.gov

Please contact me if you have any questions. I may be reached at 360-810-0144. I am also available by email.

Sincerely,

Starla Tillinghast, BSN, RN
Nurse Consultant Investigator