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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 Hospital Licensing Regulations, conducted this health and safety survey. Onsite dates: 04/03/23 to 04/05/23. Examination number: X2023-280 The survey was conducted by: Surveyor #7 Surveyor #8 Surveyor #10 (who was in orientation) The Washington Fire Protection Bureau conducted the fire life safety inspection. (See shell # 0Y0C21) During the course of the survey, surveyors also investigated the following complaint(s): #. 2022-5625 and #2023-3414.	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 received electronically by April 24th, 2023. 4. Return the REPORT electronically with the required signatures.	
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	L 315		

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L 315	Continued From page 1 services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of the hospital's policy and procedure, the hospital failed to ensure staff followed the policy on close observation and documentation for 10 of 14 Observation Records reviewed (Patient's #702, #703, #704, #705, #706, #707, #708, #709, #710 and #711). Failure to document Physician Ordered Precautions and the patients' observation level can lead to patient elopement or serious risk to patient safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Sheet Documentation Guideline" Policy # PC028, last reviewed 07/22 showed the following: a. The following should be documented every (q) 5 or q15 minutes as ordered: i. The patient's exact location. ii. Pertinent descriptions of the patient's current condition, behavior, or activity. iii. Significant patient responses to the care provided by staff. iv. Time that precautions were implemented and discontinued.	L 315		

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L 315	Continued From page 2 2. On 04/03/23 at 1:42 PM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the rounding sheets for the patients in the Women's unit. The review showed the following: a. Patient #702 was on q5-minute precautions and was missing 3 q5-minute rounds. b. Patient #703 was on q15-minute rounding and was missing 2 q15 minutes checks. c. Patient #704 was on q15-minute rounding and was missing 4 q15-minute checks. d. Patient #705 was on q15-minute rounding and was missing 4 q15-minute checks. e. Patient #706 was on q15-minute rounding and was missing 10 q15-minute checks. f. Patient #707 was on q15-minute rounding and was missing 16 q15-minute checks. g. Patient #708 was on q15-minute rounding and was missing 16 q15-minute checks. h. Patient #709 was on q15-minute rounding and was missing 4 q15-minute checks. i. Patient #710 was on q15-minute rounding and was missing 4 q15-minute checks. j. Patient #711 was on q15-minute rounding and was missing 6 q15-minute checks. 3. At the time of the review Staff #701 verified 10 of the 14 rounding sheets were missing 2 or more rounding documentation.	L 315		

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L1065	Continued From page 3	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: . Item #1 Date and time Based on record review and interview, the hospital failed to ensure that staff members completed the Comprehensive Treatment Plan to include the date and time for 5 of 7 records reviewed (Patients #701, #712, #713, #714, and #715). Failure to develop and implement an individualized, interdisciplinary treatment plan for behavioral and medical problems places the patients at risk for inappropriate, inconsistent, and delayed care, creating the potential for negative	L1065		

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L1065	Continued From page 4 patient outcomes, harm, or death. Findings included: 1. Document review of the policy titled, "Treatment planning" Policy# MS.16, last reviewed 01/22, showed the following: a. Within 72 hours of admission, the first Treatment Team meeting will be held and the Master Treatment Plan will be prepared by the multidisciplinary team and signed by the attending physician. 2. On 04/03/23 at 10:06 AM, Surveyor #7, The Nurse Manager (Staff #701), reviewed the medical record of Patient #701. Patient #701 was admitted on 03/30/23 at 6:40 PM. Patient #701 had a Master Treatment Plan (MTP) dated 04/03/23 that did not include the time of the provider/staff signature. 3. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 4. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #712 who was admitted on 03/31/23 at 12:25 AM. The review showed the patient had a MTP that showed no Psychiatric provider participation. 5. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 6. On 04/04/23 at 11:00 AM, Surveyor #7 and Staff #701 reviewed the medical record for	L1065		

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L1065	Continued From page 5 Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the multidisciplinary MTP meeting had no time documented on the form. 7. At the time of the review Staff #701 verified there was no place on the form for staff or patients to document a time on the time-sensitive document. 8. On 04/04/23 at 11:31 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 03/15/23 at 1:45 AM. The review showed no time noted on the MTP. 9. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 10. On 04/04/23 at 1:00 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 01/27/23 at 1:40 AM. The review showed no time noted on the MTP. 11. At the time of the review Staff #701 verified there was no time documented and no place on the form for staff or patients to document a time on the time-sensitive document. 12. On 04/04/23 at 3:18 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #715 who was admitted on 02/08/23 at 12:50 AM. The review showed no time noted on the MTP. 13. At the time of the review Staff #701 verified there was no time documented and no place on	L1065		

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L1065	Continued From page 6 the form for staff or patients to document a time on the time-sensitive document. Item #2 Incomplete MTP Based on document review and interview the hospital failed to ensure a multi-disciplinary treatment team completed the Master Treatment Plan (MTP) for 4 of 7 records reviewed, (Patients #701, #712, #713, and #716). Failure to ensure the development of a complete Comprehensive Treatment Plan for behavioral and medical problems places patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the policy titled, "Treatment planning" Policy# MS.16, last reviewed 01/22, showed the following: a. Within 72 hours of admission, the first Treatment Team meeting will be held and the Master Treatment Plan will be prepared by the multidisciplinary team and signed by the attending physician. i. Specific departmental strategies are written by the individual discipline members. ii. Patient goals and staff strategies will be based upon assessments conducted and records received within the first week of hospitalization. b. Goals are established in reference to specified problems. i. Goals are achievable with target dates and	L1065		

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L1065	Continued From page 7 written in measurable terms. b. Specific strategies or treatment modalities will be identified and the responsible staff/discipline will be indicated. c. The treatment plan, goals, and progress toward these goals will be reviewed and revised by the Treatment Team weekly or more often as clinically indicated. 2. On 04/03/23 at 10:06 AM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the medical record for Patient #701 who was admitted on 03/30/23 at 6:40 PM. Review of the medical record showed the following: a. Patient #701 had a MTP dated 04/03/23 with the following problems listed; Psychiatric problems i. High Risk for Suicide. ii. Danger to self with Psychosis. Medical problems iii. Substance-related detox. iv. Risk of complication during detox. v. Risk for injury related to Seizure. vii. Risk of falls. viii. Impaired skin integrity. ix. Hypertension (HTN). x. Chronic pain.	L1065		

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L1065	Continued From page 8 xi. Insomnia. xii. Asthma. xiii. Gerd. xiv. Impaired physical mobility. xv. Extremity immobilization: cast, limb, joint fixation as evidenced by splint on Left leg for ankle fracture. xvi. HTN. b. The Treatment Team was only signed by the Program Therapist. 3. Surveyor #7 interviewed the Program Therapist (Staff #702) who stated she was currently working on the MTP and had not had an opportunity to complete it due to the weekend. Staff #702 further advised they had not yet held the Multidisciplinary Master Treatment meeting. 4. At the time of the review Staff #701 verified the incomplete MTP and that it had not been completed within 72 hours of the patient's admission. 5. On 04/04/23 at 9:59 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #712 who was admitted on 03/31/23 at 12:25 AM. The review showed the patient had a MTP that showed no Psychiatric provider participation. 6. At the time of the review Staff #701 verified the incomplete MTP and that it had not been completed within 72 hours of the patient's admission.	L1065		

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L1065	Continued From page 9 7. On 04/04/23 at 11:00 AM, Surveyor #7 and Staff 3701 reviewed the medical record for Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the following: a. The multidisciplinary MTP meeting was not completed within 72 hours. No Psychiatrist was represented at the initial MTP meeting. b. The MTP update held on 01/30/23 had no Physician in attendance. 8. At the time of the review Staff #701 verified the incomplete MTP and that it had not been completed within 72 hours of the patient's admission 9. On 04/04/23 at 3:18 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #716 who was admitted on 02/08/23 at 12:50 AM. The review showed the MTP was signed by the Psychiatrist the PT, RT, and the Patient on 02/09/23. The RN signed on 02/14/23, 6 days after the patient arrived. 10. At the time of the review Staff #701 verified the MTP had not been completed within 72 hours of the patient's arrival.	L1065		
L1100	322-170.3B PSYCHIATRIC SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (b) Psychiatric services,	L1100		

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L1100	Continued From page 10 including: (i) A staff psychiatrist available for consultation daily and visits as necessary to meet the needs of each patient; and (ii) A child psychiatrist for regular consultation when hospital policy permits the admission of children or adolescents; This Washington Administrative Code is not met as evidenced by: Based on interview, and document review the hospital failed to ensure that a child psychiatrist is available for regular consultation when hospital policy permits the admission of children or adolescents. Failure to have a child psychiatrist available for consultation when the hospital has children or adolescent patients puts these patients at risk of receiving incomplete treatment. Reference: WAC 246 322 010 Definitions: (7) "Child psychiatrist" means an individual licensed as a physician under chapter 18.71 or 18.57 RCW who is board-certified or board-eligible with a specialty in child psychiatry by: (a) The American Board of Psychiatry and Neurology; or (b) The Bureau for Osteopathic Specialists, American Osteopathic Neurology and Psychiatry. Findings included: 1. On 04/03/23 at 8:30 AM, Surveyor #8, Surveyor #10, and Surveyor #7 interviewed the CEO (Staff #803) about the provision of adolescent services at the hospital. Staff #803 stated that the 2nd floor the hospital has an adolescent unit.	L1100		

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L1100	Continued From page 11 2. On 04/05/23 at 10:15 AM, the Medical Director (Staff #802) was interviewed by Surveyor #8, Surveyor #10, and Surveyor #7. During the interview, Staff #802 stated that to be a child psychiatrist requires specialized and additional medical training. He stated that he is not aware of anyone with child psychiatry training currently privileged to provide consultation at South Sound Behavioral Hospital. .	L1100		
L1295	322-200.3L RECORDS-PROGRESS NOTES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (i) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure prompt entry of initial recreational therapy assessments in the medical record for 3 of 6 patients reviewed (Patient #1004, #1005, and #1006). Failure to document initial assessments risks patient harm from unrecognized or unmet care needs, and inconsistent and unsafe care due to an incomplete medical record.	L1295		

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L1295	Continued From page 12 Findings included: 1. Document review of the hospital's policy titled, "Activity Therapy Assessment of Patients," no policy number, reviewed 01/22, showed: a. All patients admitted to South Sound Behavioral Hospital will receive a thorough assessment and evaluation. Results of assessments are reviewed and integrated by the multidisciplinary treatment team to prioritize identified problems within the interdisciplinary treatment plan. b. Activity Therapy Assessment: This assessment is completed within 72 hours of admission and includes (in part) information regarding the patient's diagnosis and orders received; physical restrictions and precautions; attitude and affect; decision-making/problem solving skills; social skills; communication and coping skills; concentration; insight; and leisure skills. Summary contents including brief history, educational needs, precipitating event, and an individualized treatment plan are also included. 2. On 04/04/23 at 1:30 PM, Surveyor #10 and the Chief Nursing Officer (Staff #1001) reviewed the medical records for Patients #1004, #1005, and #1006. The review showed the following: a. Patient #1004 was admitted on 03/04/23 at 4:40 PM. Surveyor #10 found no evidence that an activity therapy assessment had been completed within 72 hours. b. Patient #1005 was admitted on 03/03/23 at 8:00 PM. Surveyor #10 found no evidence that an activity therapy assessment had been completed within 72 hours.	L1295		

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L1295	Continued From page 13 c. Patient #1006 was admitted on 02/09/23 at 8:00 PM. Surveyor #10 found no evidence that an activity therapy assessment had been completed within 72 hours. 5. At the time of the record reviews, Staff #1001 verified there was no documentation of initial activity therapy assessments in the medical records of Patient #1004, #1005, and #1006. 6. At the time of the record reviews, Surveyor #10 interviewed the Director of Clinical Services (Staff #1002) about the responsibilities of recreational therapists. Staff #1002 confirmed that the recreational therapist is to complete an initial activity assessment of each patient within 72 hours of admission. .	L1295		
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) 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 interview and document review, the hospital failed to ensure prompt filing into the	L1390		

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L1390	Continued From page 14 clinical record of provider authentication for telephone orders and verbal orders for 7 of 16 patients (Patients #701, #713, #714, #715, #1001, #1002, and #1003). Failure to authenticate orders promptly puts patients at risk of harm from improper care and medical error. Findings included: 1. Document review of the hospital policy titled, "Medication Ordering and Prescribing," policy number PH 022, last reviewed 1/22, showed that telephone orders must be co-signed by the physician within 24 hours. Document review of the hospital policy titled, "Physician Orders," policy number RC 001, last reviewed 1/22, showed the following: a. Purpose: to provide guidelines for processing orders. b. All physician orders shall be written [in the] electronic medical record system. c. All telephone orders entered directly into the electronic medical record system by a nurse must be co-signed by the ordering physician within 48 hours after entry. 2. On 04/03/23 at 10:06 AM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the medical record for Patient #701 who was admitted on 03/30/23 at 6:40 PM. Review of the medical record showed the following: a. A telephone order for a dietary consult and a Clinical Institute Withdrawal Assessment (CIWA)	L1390		

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 _____	04/05/2023

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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L1390	Continued From page 15 Scale order was placed on 03/30/23 at 10:40 PM by a Registered Nurse (RN) (Staff #702) and authenticated by the provider on 04/03/23 at 9:54 AM, 83 hours and 34 minutes after the order was placed. b. A telephone order for the medication, Albuterol 90mcg inhalation, was placed on 03/31/23 at 1:07 PM by an RN (Staff #703) and authenticated by the provider on 04/03/23 at 9:54 AM, 68 hours and 47 minutes after the order was placed. 3. At the time of the review Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN and the dietary consult and CIWA scale orders were not authenticated within 48 hours. 4. On 04/03/23 at 2:30 PM, Surveyor #10 and the Chief Nursing Officer (Staff #1001) reviewed the electronic medical record for Patient #1001. The review showed: a. An order entered by an RN for amlodipine 5mg on 01/19/22 was not co-signed by a provider until 02/17/22 (29 days). b. An order entered by an RN for vital signs on 02/20/22 was not co-signed by a provider until 03/25/22 (34 days). c. An order entered by an RN for transfer on 03/04/23 was not co-signed by a provider until 03/10/23 (6 days). 5. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe. 6. On 04/04/23 at 11:00 AM, Surveyor #7 and	L1390		

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L1390	Continued From page 16 Staff 701 reviewed the medical record for Patient #713 who was admitted on 01/24/23 at 9:56 PM. The review showed the following: a. A medication order for Culturelle was placed on 01/26/23 at 4:17 PM by an RN (Staff #704). b. A medication order for Calcium Carbonate 500 mg was placed on 01/28/23 at 4:47 PM by an RN (Staff #705). 7. At the time of the review, the order for Culturelle and Calcium Carbonate had not been authenticated by a provider. 8. At the time of the review, Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN. 9. On 04/04/23 at 11:31 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #714 who was admitted on 03/15/23 at 1:45 AM. The review showed the following: a. A medication order for transdermal nicotine was placed on 03/18/23 at 10:51 AM, by an RN (Staff #705). b. A medication order for Quetiapine oral 100 mg was placed on 03/18/23 at 10:53 AM, by Staff #705. c. A medication order for Quetiapine oral 300 mg was placed on 03/18/23 at 10:54 AM, by Staff #705. 10. At the time of the review the 3 medication orders had not been authenticated. 11. At the time of the review, Staff #701 verified	L1390		

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L1390	Continued From page 17 the medication order was not authenticated within 24 hours after being placed by an RN. 12. On 04/04/23 at 11:45 AM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1002. The review showed: a. An order entered by an RN for transfer on 03/22/23 had not been co-signed by a provider at the time of the review (13 days). b. An order entered by an RN for discharge to higher level of care on 03/22/23 had not been co-signed by a provider at the time of the review (13 days). 13. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe. 14. On 04/04/23 at 1:30 PM, Surveyor #10 and Staff #1001 reviewed the electronic medical record for Patient #1003. The review showed an order entered by an RN for wound care consult on 02/11/23 was not co-signed by a provider until 02/15/23 (4 days). 15. At the time of the review, Staff #1001 verified that the orders had not been authenticated within the hospital policy timeframe. 16. On 04/04/23 at 1:41 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #715 who was admitted on 01/27/23 at 1:40 AM. The review showed the following: a. A medication order for Albuterol inhalation was placed on 01/27/23 at 3:20 AM, by an RN (Staff #706). The order was authenticated on 03/03/23 at 2:06 PM, 6 days after being placed by the RN.	L1390		

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L1390	Continued From page 18 17. At the time of the review Staff #701 verified the medication order was not authenticated within 24 hours after being placed by an RN. .	L1390		
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 observation, interview and document review, the hospital failed to ensure that patient menus were posted in a location easily accessible to all patients. Failure to provide a menu that is easily accessible restricts the patient's ability to select their dietary options. This inability to select dietary options puts patients at risk of harm from inadequate nutrition.	L1525		

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L1525	Continued From page 19 Findings included: 1. On 04/03/23 between 10:00 AM and 11:00 AM, Surveyor #8 toured units on the 2nd and 3rd floors with Infection Preventionist (Staff #801). Staff #801 was interviewed regarding where food is served. He stated that patients are served primarily in the dining room on the 1st floor, but there are times, such as during the first 24 hours when the patient is first admitted and if illness requires isolation, a patient is served on the unit. 2. On 04/03/23 between 2:00 PM and 2:30 PM Surveyor #8 toured units on the 2nd and 3rd floor units with Staff #801. Surveyor #8 observed that Units 3BW and 2AW did not have a posted menu, and Units 2BW, 2BE and 2AE had menus that were not current. 3. On 04/03/23 at 8:30 PM, Surveyor #8 interviewed Staff #801 who acknowledged these menus were not current or absent. 	L1525		

South Sound Behavioral Hospital
Plan of Correction for
State Licensing or Medicare Hospital/Critical Access Hospital Survey
4/3/2023-4/5/2023
Examination Number: X2023-280
Case Number: 2022-5625 and 2023-3414

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

Verified by Mayer 10/23/23 Rec: 4/24/23 App: 4/27/23

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

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
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: L1065 . Item #1 Date and time Based on record review and interview, the hospital failed to ensure that staff members completed the Comprehensive Treatment Plan to include the date and time for 5 of 7 records reviewed (Patients #701, #712, #713, #714, and	On 4/5/2023, the new master treatment plan form/document was revised to ensure that the new form/document will reflect the time treatment plan was done and signed. This form was approved by the governing board on 4/21/2023 and will be implemented on 4/24/2023. On 4/21/2023, treatment team leadership met and reviewed the current process. The following were decided and will be implemented: 1. Providers are now assigned specific unit to ensure their participation in treatment meetings is consistent. 2. Treatment team meeting schedule was revised to ensure participation from treatment team members is in compliance with the approved policy and procedure. 3. Treatment team agenda was revised. 4. Clinical services, nursing and providers were retrained on treatment planning with emphasis on completion and timelines. The New Hire	Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Director of Clinical Services (DCS)	4/21/2023 5/1/2023	Approved New Treatment Plan Form/Document Attendance to scheduled treatment meeting will be documented and submitted to the Clinical Services Director. This will be monitored for 100% compliance for 3 consecutive months. Any noncompliance will be corrected and staff identified will be reeducated by the CMO. Results will be reported by the CMO, CNO and DCS monthly to the Quality/PI, MedExec and Governing Board . Clinical Services Director or designee

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

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

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
Based on document review and interview the hospital failed to ensure a multi-disciplinary treatment team completed the Master Treatment Plan (MTP) for 4 of 7 records reviewed, (Patients #701, #712, #713, and #716). Failure to ensure the development of a complete Comprehensive Treatment Plan for behavioral and medical problems places patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the policy titled, "Treatment planning" Policy# MS.16, last reviewed 01/22, showed the following: a. Within 72 hours of admission, the first Treatment Team meeting will be held and the Master Treatment Plan will be prepared by the multidisciplinary team and signed by the attending physician. i. Specific departmental strategies are written by the individual discipline members. ii. Patient goals and staff strategies will be based upon assessments conducted and records received within the first week of hospitalization. b. Goals are established in reference to specified problems. i. Goals are achievable with target dates and written in measurable terms. b. Specific strategies or treatment modalities will be identified and the responsible staff/discipline will be indicated. c. The treatment plan, goals, and progress toward these goals will be reviewed and revised by the Treatment Team weekly or more often as clinically indicated. 2. On 04/03/23 at 10:06 AM, Surveyor #7 and the Nurse Manager (Staff #701) reviewed the medical				

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

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

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

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

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

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within 72 hours. c. Patient #1006 was admitted on 02/09/23 at 8:00 PM. Surveyor #10 found no evidence that an activity therapy assessment had been completed within 72 hours. 5. At the time of the record reviews, Staff #1001 verified there was no documentation of initial activity therapy assessments in the medical records of Patient #1004, #1005, and #1006. 6. At the time of the record reviews, Surveyor #10 interviewed the Director of Clinical Services (Staff #1002) about the responsibilities of recreational therapists. Staff #1002 confirmed that the recreational therapist is to complete an initial activity assessment of each patient within 72 hours of admission.				
L1390 322-210.3F PROCEDURES-AUTHENTICATE 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) 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 interview and document review, the hospital failed to ensure prompt filing into the clinical record of provider clinical record of provider authentication for telephone orders and verbal orders for 7 of 16 patients (Patients #701, #713, #714, #715, #1001, #1002, and #1003). Failure to authenticate orders promptly puts patients at risk of harm from improper care and medical error.	Retraining of providers on authentication of orders was completed on 4/20/2023. The New Provider Orientation training was updated to reflect this expectation. RN chart check was revised to include check of providers authentication of order made within 24 hours.	CMO and Director of Pharmacy CNO	4/20/2023	Documented attestation to the training provided for all providers. Any provider not completing the education by 4/30/23 will be removed from the schedule Director of Pharmacy will perform random audits monthly on timely authentication of orders (48 hours). This will be monitored by the Director of

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

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

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

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

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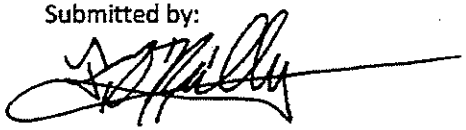
nutritional requirements; (iv) Provide a variety of foods; (v) Are approved in writing by the dietitian; (vi) Are posted in a location easily accessible to all patients; and (vii) Are retained for one year; This Washington Administrative Code is not met as evidenced by: Based on observation, interview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

Submitted by:



Terrance O'Reilly
Chief Executive Officer
South Sound Behavioral Hospital
Date: 4/24/23

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

10/11/23

Ms. Navarete
Smokey Point Behavioral Hospital

Dear Ms. Navarete

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

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

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

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

Sincerely,

Marnie Rathbun
Survey Team Leader