State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013220	A. BUILDING: _____ B. WING _____	01/30/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 01/24/23 to 01/27/23 & 01/30/23 Examination number: 2022-1150 The survey was conducted by: Surveyor #3 Surveyor #5 Surveyor #8 Surveyors investigated complaint #2023-311 during the survey. The Washington Fire Protection Bureau conducted the fire life safety inspection (See Shell # X9WX21).	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on March 6, 2023. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter.	
L 220	322-030.3C BACKGROUND-SIGNATURE WAC 246-322-030 Criminal history, disclosure, and background inquiries. (3) The licensee or license applicant shall: (c) Require the individual to	L 220		

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L 220	Continued From page 1 sign an acknowledgement statement that a background inquiry will be made; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure staff had signed a background check disclosure statement for 2 of the 11 files reviewed. Failure to inform staff during pre-employment that a background check would be performed denies the staff the right to protect personal information or disclose information and being made aware of conditions provided by Washington State laws. Findings included: 1. On 01/26/23 between 10:30 AM and 1:00 PM, Surveyor #8 reviewed personnel files with the Human Resource Business Partner (Staff #801). Document review of the personnel files for 11 staff members took place. Verification of a signed disclosure statement informing of a background check for a Registered Nurse (Staff #804) and a contracted Pharmacy Assistant (Staff #803), could not be found. 2. At the time of the review, Staff #801 stated that records confirming signature of a signed disclosure statement were not available. .	L 220		
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 320		

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L 320	Continued From page 2 written policies and procedures consistent with this chapter and services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: Item #1 Acknowledgement of Grievance Based on interview, document review, and review of policies and procedures, the hospital failed to acknowledge receipt of the patient grievances within stated time frames for 4 of 4 grievances reviewed (Patient #501, #502, #503, and #504). Failure to meet complaint response times is a violation of the patient's right to a timely response to concerns. Findings included: 1. Document review of the hospital's policy and procedure titled, "General Grievances and patient Advocacy," policy number 11492705, revised 09/20, showed the following: a. The Patient Advocate or Patient Advocate Designee must acknowledge receipt of the Patient Grievance within 24 business hours of becoming aware of same. b. If necessary, the Patient Advocate must arrange for translation and/or interpreter for the Patient Grievance Process. c. The Patient Advocate provides the patient, patient representative and/or family member an	L 320		

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L 320	Continued From page 3 opportunity to voice their concerns. Also assures them that the Patient Grievance will not subject the patient to any coercion, discrimination, interruption in care, or reprisal. 2. On 01/30/22 at 1:30 PM, Surveyor #5 and the Quality Director (Staff #501) reviewed the hospitals Complaint and Grievance process. The review showed the following: a. Patient #501's grievance was dated 10/24/22. The grievance was received by the Quality Department on 10/31/22. On 11/15/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 11 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital acknowledged receipt of the patient grievance within 24 business hours. b. Patient #502's grievance card was received by the Quality Department on 11/02/22. On 12/06/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 20 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital acknowledged receipt of the patient grievance within 24 business hours. c. Patient #503's grievance card was dated 10/25/22. The grievance was received by the Quality Department on 11/01/22. On 11/17/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 12 business days after received by the Quality Department).	L 320		

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L 320	Continued From page 4 Surveyor #5 found no evidence the hospital acknowledged receipt of the patient grievance within 24 business hours. d. Patient #504's grievance was dated 12/11/22. The grievance was received by the Quality Department on 12/20/22. Surveyor #5 found no evidence the hospital acknowledged receipt of the patient grievance. 3. At the time of the review, Staff #501 verified the finding and stated that the grievance process was not completed as directed by hospital policy. Item #2 Timely Investigation and Resolution of Grievance Based on interview, document review, and review of policies and procedures, the hospital failed to investigate, determine resolution, and provide written notification to complainants in response to grievances within stated time frames for 4 of 4 grievances reviewed (Patient #501, #502, #503, and #504). Failure to meet complaint response times is a violation of the patient's right to a timely response to concerns. Findings included: 1. Document review of the hospital's policy and procedure titled, "General Grievances and patient Advocacy," policy number 11492705, revised 09/20, showed the following: a. The Patient Advocate or Patient Advocate Designee will investigate the identified Patient	L 320		

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L 320	Continued From page 5 Grievance and determine the resolution within 7 business days of receipt of the Patient Grievance. b. Patient Grievances involving situations in which the patient is in immediate danger must be investigated and resolved in a timely manner. This requires that immediate and reasonable steps to be undertaken to diminish risk of danger/harm to the patient. c. The Patient Advocate will notify the patient, family member, or patient representative of the results in writing. 2. On 01/30/22 at 1:30 PM, Surveyor #5 and the Quality Director (Staff #501) reviewed the hospitals Complaint and Grievance process. The review showed the following: a. Patient #501's grievance was dated 10/24/22. The grievance was received by the Quality Department on 10/31/22. On 11/15/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 11 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital determined resolution or notified the patient, family member, or patient representative of the results in writing within 7 business days. b. Patient #502's grievance card was received by the Quality Department on 11/02/22. On 12/06/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 20 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital	L 320		

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L 320	Continued From page 6	L 320		

determined resolution or notified the patient, family member, or patient representative of the results in writing within 7 business days.

c. Patient #503's grievance card was dated 10/25/22. The grievance was received by the Quality Department on 11/01/22. On 11/17/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 12 business days after received by the Quality Department).

Surveyor #5 found no evidence the hospital determined resolution or notified the patient, family member, or patient representative of the results in writing within 7 business days.

d. Patient #504's grievance was dated 12/11/22. The grievance was received by the Quality Department on 12/20/22.

Surveyor #5 found no evidence the hospital determined resolution or notified the patient, family member, or patient representative of the results in writing within 7 business days.

3. At the time of the review, Staff #501 verified the finding and stated that the grievance process was not completed as directed by hospital policy.

Item #3 Notice of Incomplete Investigation

Based on document review and interview, the hospital failed to provide written notification to complainants in response to grievances requiring ongoing investigation within stated time frames for 3 of 4 grievances reviewed (Patient #501, #502, and #503).

Failure of the hospital to provide written notice in

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L 320	Continued From page 7 response to grievances requiring ongoing investigation is a violation of the patient's right to a timely response to concerns. Findings included: 1. Document review of the hospital's policy and procedure titled, "General Grievances and patient Advocacy," policy number 11492705, revised 09/20, showed that if the hospital is unable to complete the investigation and/or resolution within 7 business days, the patient, family member or patient representative will be notified, in writing, by the Patient Advocate and/or Patient Advocate designee that the investigation is ongoing, while furnished in a timeframe for expected completion. 2. On 01/30/22 at 1:30 PM, Surveyor #5 and the Quality Director (Staff #501) reviewed the hospital's Complaint and Grievance process. The review showed the following: a. Patient #501's grievance was dated 10/24/22. The grievance was received by the Quality Department on 10/31/22. On 11/15/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 11 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital notified the patient, family member, or patient representative in writing that the hospital was unable to complete the investigation and/or determine resolution of the grievance within 7 business days. b. Patient #502's grievance card was received by the Quality Department on 11/02/22. On 12/06/22, the hospital sent a combined acknowledgment	L 320		

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L 320	Continued From page 8 and investigation closure letter to the patient (a period of 20 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital notified the patient, family member, or patient representative in writing that the hospital was unable to complete the investigation and/or determine resolution of the grievance within 7 business days. c. Patient #503's grievance card was dated 10/25/22. The grievance was received by the Quality Department on 11/01/22. On 11/17/22, the hospital sent a combined acknowledgment and investigation closure letter to the patient (a period of 12 business days after received by the Quality Department). Surveyor #5 found no evidence the hospital notified the patient, family member, or patient representative in writing that the hospital was unable to complete the investigation and/or determine resolution of the grievance within 7 business days. d. Patient #504's grievance was dated 12/11/22. The grievance was received by the Quality Department on 12/20/22. Surveyor #5 found no evidence the hospital notified the patient, family member, or patient representative in writing that the hospital was unable to complete the investigation and/or determine resolution of the grievance within 7 business days. 3. At the time of the review, Staff #501 verified the finding and stated that the grievance process was not completed as directed by hospital policy.	L 320		

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L 320	Continued From page 9	L 320		
L 390	322-035.1R POLICIES-PATIENT TRANSFER 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: (r) Transferring patients to other health care facilities or agencies; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff notified the emergency contact when patients experienced a change in condition that required a transfer to an acute care hospital for emergency medical treatment for 2 of 4 patients reviewed (Patient #308, #309). Failure of the hospital to ensure that staff followed the policies and procedures when transferring patients requiring emergency medical care risks delay in emergency contacts being informed. Findings included: 1. Document review of the hospital's policy and procedure titled, "Transfer to Another Facility," PolicyStat ID number 12635818, last approved 12/22, showed the following: a. The Registered Nurse (RN) assesses and determines the patient has an unstable medical condition. The RN contacts the physician, and	L 390		

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L 390	Continued From page 10	L 390		

they provide orders to transfer the patient to the emergency department.

b. The staff will discuss with the patient whether they wish to have relatives notified. If yes, have the patient complete a Consent to Release Information form. Contact the relative and notify them of the transfer and the receiving facility's telephone number. In an emergency situation, a transfer can be completed without consent.

c. Complete a transfer form and place a copy in the chart.

d. The RN will document in the nursing progress notes, the name and discipline of the individual in which a patient report was given and reason for the transfer. The RN will also document if a family/next of kin was notified.

Document review of the hospital form titled, "Patient Demographic Form," Form number IP-ADW-054-14, last updated 01/25/22, showed a section labeled "Emergency Contact Information". The section included a statement "Patient consents to have emergency contact notified if patient is transferred to another hospital (including an ER)" with a space for the patient to elect YES or NO and sign their initials.

2. On 01/30/23, Surveyor #3 reviewed the medical records of 4 patients who had been transferred to an Emergency Room for treatment for changes in their condition. The review showed the following:

a. On 06/07/22, Patient #308 was transferred to an outside local hospital for acute delirium and confusion. The Patient Demographic Form was signed and initialed on 08/05/22 consenting for

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L 390	Continued From page 11 the patient's emergency contact to be notified if the patient was transferred to another hospital. The transfer form (From Inpatient to Medical Hospital) was blank under the section labeled emergency contact notified. Surveyor #3 found no documentation that the patient's emergency contact was notified. b. On 01/01/23, Patient #309 was transferred to a local hospital Emergency Department for the treatment of decreasing level of consciousness and increased respiratory rate (breathing). The Patient Demographic Form was signed and initialed on 12/29/22 consenting for the patient's emergency contact to be notified if the patient was transferred to another hospital. The transfer form (From Inpatient to Medical Hospital) was marked "No" under the section labeled emergency contact notified. Surveyor #3 found no documentation that the patient's emergency contact was notified. 3. On 01/30/23 at approximately 12:30 PM, Surveyor #3 discussed the above findings with the Director of Quality (Staff #306) who acknowledged the patients emergency contact should have been notified.	L 390		
L 540	322-050.5B CURRENT 1ST AID CARD WAC 246-322-050 Staff. The licensee shall: (5) Assure all patient-care staff including those transporting patients and supervising patient activities, except licensed staff whose professional training exceeds first-responder training, have	L 540		

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L 540	Continued From page 12 within thirty days of employment: (b) Current first-aid cards from instructors certified as in (a) of this subsection; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure staff completed first aid training for 1 out of the 11 files reviewed. Failure to provide staff members appropriate first aid training puts patients and staff at risk of harm due to delayed medical care. Findings included: 1. On 01/26/23 between 10:30 AM and 1:00 PM, Surveyor #8 reviewed human resource files with the Human Resource Business Partner (Staff #801) for 11 staff members. Verification of first aid training completion for Patient Care Assistant (PCA) (Staff #802) could not be found. 2. At the time of the review, Staff #801 stated that the first aid training records for Staff #802 were not available, and that first aid training requirement is not in the PCA job description. .	L 540		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's	L 615		

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L 615	Continued From page 13 association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital failed to ensure verification of initial Tuberculosis screening was documented and available for 1 contracted Pharmacy Assistant (Staff #803). Failure to ensure that staff members have appropriate Tb screening puts patients and staff at risk of harm from infection. Findings included: 1. On 01/26/23 between 10:30 AM and 1:00 PM, Surveyor #8 reviewed with the Human Resource Business Partner (Staff #801) human resource files for 11 staff members. Verification of annual Tb screening records for 1 contracted Pharmacy Assistant (Staff #803) was not available. 2. During the review, Human Resource Manager Staff #801 stated that records for TB screening of the Staff #803 were not available.	L 615		

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L 615	Continued From page 14	L 615		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 1 of 4 patients reviewed (Patients #301). Failure to remove patients from seclusion at the earliest possible time risks loss of dignity, loss of personal freedom, and psychological and physical harm to the patient. Findings included: 1. Document review of the hospital's policy and procedure titled, "Seclusion and Restraint," PolicyStat number 111667825, last revised 07/21, showed that seclusion is considered to be an unusual, high-risk event that warrants timely assessment and continuous monitoring. Staff are	L1145		

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RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L1145	Continued From page 15	L1145		

educated to discontinue seclusion at the earliest time possible when the patient can demonstrate compliance with identified release criteria. The patient is to be released from seclusion once they have met the behavioral criteria as defined by the provider seclusion order and is no longer an imminent risk.

2. On 01/26/23, Surveyor #3 reviewed the medical records of four patients who were placed in seclusion during their hospitalization. The review showed the following:

a. Patient #301 was a 32-year-old patient placed in seclusion on 12/03/22 at 8:30 PM for threatening staff, pouring water on patients, and jumping over nurse's station to threaten other patients. The patient received an intramuscular injection of haloperidol (a medication used for agitation), diphenhydramine (an antihistamine with sedating properties) and lorazepam (a medication used for anxiety) just prior to the time he was place in seclusion.

b. While in seclusion, the medical record showed that the patient's condition improved and the patient's behavior was described as "resting quietly", "alert and oriented", or "processing" from 12/03/23 at 9:05 PM until his release from seclusion at 12/04/23 at 2:40 AM, a period of 5 hours and 35 minutes. The medical record showed the patient requested release from seclusion on 12/03/23 at 8:55 PM and 11:30 PM. The surveyor could find no documentation that showed that the patient had been reassessed by the nursing staff for an earlier release.

3. On 01/26/23 at 11:00 PM, Surveyor #3 interviewed the House Supervisor (Staff #304) about the extended seclusion period for Patient

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L1145	Continued From page 16 #301. Staff #304 confirmed the finding and stating the documented behavior did not warrant continued use of seclusion. 4. A follow-up interview on 01/26/23 at approximately 12:00 PM with the Director of Nursing (Staff #305) confirmed the finding but acknowledged the documentation did not adequately address the patient's behavior or nursing staff's assessment for continuation of seclusion.	L1145		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This Washington Administrative Code is not met as evidenced by: Based on observation, document review, and interview, the hospital failed to have all the required emergency supplies available for patient care for 3 of 3 patient care units reviewed. Failure to have the required emergency supplies available risks delayed patient care and treatment. Findings included: 1. Document review of the hospital policy and	L1165		

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L1165	Continued From page 17 procedure titled, "Emergency Cart," PolicyStat ID number 12462920, last approved 10/22, showed that the hospital will maintain the emergency cart, automated external defibrillator (AED), and oxygen. Each facility will maintain a list of medical supplies present in each cart. Drawers on each cart are labeled to identify contents and location for ease of use. All carts will be opened monthly and checked for content and items near expiration date. Document review of the hospital document titled, "Emergency Cart Check List," did not include airways, intravenous fluids (IV), IV catheters and associated tubing as items to check if the emergency cart is opened. 2. On 01/24/23 at 08:40 AM, Surveyor #3 and the Infection Preventionist (Staff #301) toured the "Meadows" patient care unit. The surveyor inspected the emergency cart and observed that there were no airways, IV fluids or associated tubing and catheters within the cart. 3. At the time of the observation, Surveyor #3 interviewed the Infection Preventionist (Staff #301) about the contents of the emergency cart. Staff #301 confirmed the findings and stated that the emergency carts do not contain oral or nasal airways. She also acknowledged that IV's and associated tubing and catheters were not part of the hospital's emergency cart contents. 4. On 01/24/23 at 2:40 PM, Surveyor #3 and a Registered Nurse (Staff #302) inspected the emergency cart located on the "Cedar" patient care unit. The surveyor observed that there was no suction tubing available for the portable suction machine. Similarly, the surveyor found no airways, no IV fluids or associated IV catheter	L1165		

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L1165	Continued From page 18 and tubing within the emergency cart. Staff #302 confirmed the observations. 5. On 01/25/23 at 9:10 AM, Surveyor #3 and the House Supervisor (Staff #303) toured the "Sunrise" patient care unit. The surveyor inspected the emergency cart and observed that the multifunctional pads attached to the AED were beyond the manufacturer's expiration date of 01/02/23. Similarly, the surveyor found no airways, no IV fluids or associated IV catheters and tubing within the emergency cart.	L1165		
L1260	322-200.3E RECORDS-SIGNED ORDERS 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: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This Washington Administrative Code is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital failed to ensure medical staff promptly signed and authenticated verbal or telephone orders taken by a nurse for initiation of seclusion or physical restraint as observed in 3 of 4 records reviewed (Patient # 303, #302, #303).	L1260		

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L1260	Continued From page 19 Failure to authenticate verbal or telephone orders for initiation of seclusion or physical restraint risks treatment errors and violation of patient rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Provider Orders Guidelines," PolicyStat number 11667813, last approved 06/22, showed that all telephone and verbal orders will be authenticated within forty-eight hours by the provider who gave the order. In the event, that is not possible, the attending physician can co-sign the order. Document review of the hospital document titled, "Medical Staff Rules and Regulations," last approved 09/22 showed that all orders must be authenticated, dated, and timed by the physician or allied health provider issuing the order. 2. On 01/26/23, Surveyor #3 reviewed the medical records of four patients who were placed in physical holds or seclusion during their hospitalization. The review showed the following: a. Patient #301 was a 32-year-old patient placed in seclusion on 12/03/22 at 8:30 PM for threatening staff, pouring water on patients, and jumping over the nurse's station to threaten other patients. The surveyor could find no documentation that the ordering physician or attending physician had signed the telephone orders received by the nurse. b. Patient #302 was a 18-year-old patient admitted to the hospital on 07/22/22 who was placed in several physical holds and seclusion episodes during their hospitalization. The surveyor could find no documentation that the	L1260		

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L1260	Continued From page 20 ordering provider or attending physician had signed the telephone orders received by the nurse on the following dates: 07/29/22, 08/01/23 (3 episodes), 08/06/22, 08/08/22, 08/14/22, and 08/24/22. c. Patient #303 was a 60-year-old patient placed in a physical hold and subsequent seclusion following physical pounding on lockers and verbally threating to harm staff and other patients on 08/19/22 at 9:22 PM. The surveyor could find no documentation that the ordering physician or attending physician had signed the telephone orders received by the nurse. 3. A follow-up interview on 01/26/23 at approximately 12:00 PM with the Director of Nursing (Staff #305) and the Quality Director (Staff #306) confirmed the findings and acknowledged that one of the provider staff with many of the missing countersignatures worked primarily via tele-medicine and did not come into the hospital.	L1260		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: Item #1- Patient Identification	L1375		

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L1375	Continued From page 21 Based on observation, interview, and document review, the hospital failed to ensure staff members followed its procedure for identification of patients prior to medication administration, as demonstrated by 2 of 5 patients observed (Patients #304, #305). Failure to follow the hospital's patient identification process prior to medication administration places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration - General Guidelines," PolicyStat ID number 11667812, last approved 06/22, showed that patients shall be identified before medication is administered utilizing the five rights (right patient, right dose, right route, right time, and right medication) and two patient identifiers (name and date of birth). Other identifiers may be used including date of admission, patient identification number, and patient identification sticker. 2. On 01/24/23 at 8:45 AM, Surveyor #3 and the House Supervisor (Staff #303) observed the nursing staff administer morning medications on the "Meadows" inpatient unit. The observation showed the following: a. A Registered Nurse (Staff #307) addressed the patient (Patient #304) by their first name. Staff #304 then administered the medications to the patient without using two approved identifiers. b. A Registered Nurse (Staff #307) addressed a patient (Patient #305) at the medication window	L1375		

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L1375	Continued From page 22 by their first name. Staff #304 then handed the medication to the patient without using two approved identifiers. 3. Following the morning medication pass, Surveyor #3 interviewed the nurse (Staff #307) about what was observed. Staff #307 stated that they (staff) knew their patients and did not always ask them for their full name and date of birth when administering medications. The nurse relayed that patients often remove their hospital identification band which precluded them from using the barcode scanner. Item #2 - Duplicate Drug Therapy Based on record review, interview, and review of hospital policy and procedures, hospital staff failed to follow its procedure and recognized standards of care for duplicate drug therapy for 3 of 3 patient records reviewed (Patient #304, #306, #307). Failure to follow the hospital's medication administration and patient assessment processes places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration - General Guidelines," PolicyStat ID number 11667812, last approved 06/22, showed that medications shall be administered in accordance with orders of the prescribing provider. If medication orders seem to be unrelated to the patient's current condition, the provider is to be contacted for clarification prior to administration of the medication.	L1375		

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L1375	Continued From page 23 2. On 01/24/23 at 3:15 PM, Surveyor #3 reviewed the medical record for Patient #306 who was admitted on 01/18/23 for treatment of symptoms of psychosis. Surveyor #3 reviewed the physician medication orders and the medication administration reports and observed: a. On 01/18/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 8:05 PM -Lorazepam 2 mg by mouth at 8:06 PM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders. b. On 01/19/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 3:43 AM -Lorazepam 2 mg by mouth at 3:43 AM -Haloperidol 5 mg by mouth at 9:27 AM -Lorazepam 2 mg by mouth at 9:27 AM -Haloperidol 5 mg by mouth at 2:25 PM -Lorazepam 2 mg by mouth at 2:25 PM -Haloperidol 5 mg by mouth at 10:22 PM -Lorazepam 2 mg by mouth at 10:22 PM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders.	L1375		

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L1375	Continued From page 24 c. On 01/20/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 10:28 PM -Lorazepam 2 mg by mouth at 10:28 PM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders. d. On 01/24/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 5:05 AM -Lorazepam 2 mg by mouth at 5:05 AM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders. e. On 01/25/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 9:13 AM -Lorazepam 2 mg by mouth at 9:14 AM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders. 3. On 01/24/23 at 3:15 PM, Surveyor #3 reviewed the medical record for Patient #307 who was admitted on 01/22/23 for treatment of acute	L1375		

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L1375	Continued From page 25 psychotic disorder. Surveyor #3 reviewed the physician medication orders and the medication administration reports and observed: a. On 01/23/23, Patient #306 received duplicate medication therapy for agitation including: -Haloperidol 5 mg by mouth at 6:38 AM -Lorazepam 2 mg by mouth at 6:39 AM -Haloperidol 5 mg by mouth at 10:51 AM -Lorazepam 2 mg by mouth at 10:50 AM The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #3 found no evidence that hospital staff clarified the physician orders. 4. Surveyor #3 found similar duplicate medication therapy administration for Patient # 304 on 01/21/23. 5. On 01/30/23 at 1:30 PM, Surveyor #3 interviewed the Chief Medical Officer (CMO) (Staff #308) about duplicate drug therapy. Staff #308 stated that he prefers less "prn" (as needed) medications are utilized in the facility. The surveyor reviewed the above referenced incidents of duplicate drug therapy administration with the CMO. Staff #308 acknowledged medication orders should be clarified if similar indications are used. Item #3 - Medication Administration outside of Provider Orders Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff followed its policy for safe	L1375		

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L1375	Continued From page 26 medication administration for 2 of 2 patient records reviewed (Patient #306, #307). Failure to follow the hospital's medication administration and patient assessment processes places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration - General Guidelines," PolicyStat ID number 11667812, last approved 06/22, showed that medications shall be administered in accordance with orders of the prescribing provider. 2. On 01/24/23 at 3:15 PM, Surveyor #3 reviewed the medical record for Patient #306 who was admitted on 01/18/23 for treatment of symptoms of psychosis. Surveyor #3 reviewed the provider medication orders and the medication administration report and found the following: a. A provider wrote an order for the patient to receive trazodone (an antidepressant medication) 50 mg by mouth at bedtime as needed for insomnia. The provider's medication orders stated the medication may be repeated (given again) one hour after the initial dose of medication is given if the initial dose is not effective. b. On 01/23/23 at 9:37 PM, a nurse administered 50 mg of trazodone to Patient #306 for insomnia. c. On 01/23/23 at 10:16 PM, a nurse administered a second additional dose of 50 mg of trazodone which was 21 minutes too early before the minimal time between medication	L1375		

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L1375	Continued From page 27 doses as stated in the provider's order. Surveyor #3 found no evidence that the hospital staff notified the provider prior to administering the medication outside of the stated medication order instructions. d. A provider wrote an order for the patient to receive haloperidol 5 mg by mouth as needed for psychotic agitation. The provider's medication order also stated the medication was not to exceed three doses in a twenty-four-hour period. e. A provider wrote an order for the patient to receive diphenhydramine 50 mg by mouth for dystonia prevention whenever haloperidol is given (linked medications). The provider's medication order also stated the medication was not to exceed three doses in a twenty-four-hour period. f. A provider wrote an order for the patient to receive lorazepam 2 mg by mouth for agitation. The provider's medication order also stated the medication was not to exceed three doses in a twenty-four-hour period. g. On 01/19/23, Patient #306 received the following as needed medications: -Haloperidol 5 mg by mouth at 3:43 AM, 9:27 AM, 2:25 PM and 10:22 PM -Diphenhydramine 50 mg by mouth at 3:43 AM, 9:26 AM, 2:25 PM, and 10:22 PM. -Lorazepam 2 mg by mouth at 3:43 AM, 9:27 AM, 2:25 PM, and 10:22 PM The surveyor noted the patient received three different medications 4 times in 18 hours and 39 minutes which is outside the stated parameters of	L1375		

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L1375	Continued From page 28 the medication order instructions. Surveyor #3 found no evidence that the hospital staff notified the provider prior to administering the medication outside of the stated medication order instructions. 3. At the time of the review, Investigator #3 interviewed the House Supervisor (Staff #303) who confirmed the findings that staff had administer medications outside of the provider orders. Item #4 - CIWA Assessment and Reassessment Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff members completed and documented assessments and reassessments after each "as needed" (PRN) medication intervention for alcohol withdrawal as evidenced by 5 of 5 medical records reviewed (Patient #308, #310, #311, #312, and #313). Failure to assess and reassess patients after medication administration as part of an alcohol withdrawal protocol risks inconsistent, inadequate, or delayed relief of symptoms including anxiety, agitation, tremors, and sensorium. Findings included: 1. Document review of the hospital policy titled, "CIWA-AR and COWS," PolicyStat ID number 12152810, last approved 09/22, showed the purpose of the policy was to provide guidelines for early recognition and appropriate interventions based on a symptom triggered assessment of adult patients at risk for experiencing substance (alcohol) withdrawal.	L1375		

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	013220	A. BUILDING: _____ B. WING _____	01/30/2023

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RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L1375	Continued From page 29 Each item on the scale for CIWA-AR (Clinical Institute Withdrawal Assessment of Alcohol -Revised) is scored separately. A sum of the scores for each category provides a value that correlates with the severity index and intervention type and dose of medication. Medication will be administered based on the system triggered score. Document review of the hospital policy titled, "Medication Administration - General Guidelines," PolicyStat ID number 1167812, last approved 06/22, showed that medications should be administered in accordance with the orders of the prescribing provider. If the dose seems excessive considering the patient's age, condition, and other factors, the provider is contacted for clarification prior to the administration of the medication. Document review of the hospital form titled, "Clinical Institute Withdrawal Assessment (CIWA)," form number (CIWA) SPR-FSW-014-05, last updated 08/23/22, showed under procedures that prophylactic medication should be started for any patient with a total CIWA-AR score of 8 or greater. Document vital signs and CIWA-AR assessment scores. "The CIWA-AR scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-AR score of 8 or greater provides the best means to prevent the progression of withdrawal." Document review of the alcohol withdrawal protocol medication orders showed that lorazepam (a medication used for anxiety) 2 mg by mouth is to be given every two hours as needed for alcohol detoxication. If CIWA score is	L1375		

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L1375	Continued From page 30 greater than 8 or less than or equal to 15. Give until CIWA score is less or equal to 8. Document review of the alcohol withdrawal protocol medication orders showed that lorazepam (a medication used for anxiety) 2 mg by mouth is to be given every hour as needed for alcohol detoxication. If CIWA score is greater than 15 or diastolic blood pressure greater than 110 mm Hg. Give until CIWA score is less or equal to 15 or diastolic blood pressure less than 110 mm Hg. 2. On 01/24/23 at 10:51 AM, Surveyor #3 and Nursing Supervisor (Staff #303) reviewed the medical record of Patient #310 who was admitted for treatment of alcohol dependence. The review showed: a. On 01/24/23 at 10:11 PM, Patient #310 was assessed and evaluated to have a CIWA score of 9 and received appropriate medication. The patient was not assessed until 01/25/23 at 1:34 AM (1 hour and 23 minutes late beyond the required reassessment time of 2 hours). The patient was reassessed with a score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given). b. On 01/25/23 at 9:06 AM, the patient received a CIWA score of 9 and was appropriately medicated. The patient was not reassessed until 01/25/23 at 12:07 PM (1 hour and 1 minute late beyond the required reassessment time of 2 hours). c. On 01/25/23 at 1:58 PM, the patient received a CIWA score of 12 and was appropriately medicated but was reassessed late (1 hour and	L1375		

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L1375	Continued From page 31 47 minutes). d. On 01/25/23 at 9:26 PM, the patient received a CIWA score of 10 and was appropriately medicated. The patient was not reassessed within 2 hours as required by the protocol nor was assessed at 2:00 AM as required by provider orders (routine CIWA assessments every 6 hours). e. On 01/26/23 at 8:15 AM, the patient received a CIWA score of 9 and was appropriately medicated. The patient was not reassessed within 2 hours as required by the protocol. f. On 01/26/23 at 2:04 PM, the patient received a CIWA score of 11 and was appropriately medicated. The patient was not reassessed within 2 hours as required by the protocol. g. On 01/26/23 at 8:48 PM, the patient received a CIWA score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given). The patient was not assessed at 2:00 AM as required by provider orders (routine CIWA assessments every 6 hours). h. On 01/27/23 at 8:14 AM, the patient received a CIWA score of 3 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given). 3. On 01/25/23 at 12:45 PM, Surveyor #3 reviewed the medical record of Patient #311 who was admitted for treatment of alcohol dependence. The review showed: a. On 01/21/23 at 10:32 PM, Patient #311 was	L1375		

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L1375	Continued From page 32 assessed and evaluated to have a CIWA score of 9 and received appropriate medication. The patient was not reassessed within 2 hours as required by the protocol. Next, the patient was not assessed at 2:00 AM as required by provider orders (routine CIWA assessments every 6 hours). b. On 01/22/23, the patient was not assessed at 8:00 AM as required by provider orders (routine CIWA assessments every 6 hours). Eventually, the patient was assessed at 10:34 AM, (12 hours and 2 minutes after the last assessment) and received a CIWA score of 6. c. On 01/22/23 at 3:21 PM, the patient was assessed (1 hour and 21 minutes late) and received a CIWA score of 5 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given). d. On 01/22/23 at 8:49 PM, the patient was assessed and received a CIWA score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given). e. On 01/23/23 at 3:05 AM, the patient received a CIWA score of 9 and was appropriately medicated. The patient was not reassessed within 2 hours as required by protocol. f. On 01/23/23 at 8:56 AM, the patient received a CIWA score of 9 and was appropriately medicated. The patient was not reassessed within 2 hours as required by protocol. g. On 01/23/23 at 3:38 PM, the patient was assessed (1 hour and 33 minutes late) and	L1375		

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L1375	Continued From page 33	L1375		

received a CIWA score of 9 and was appropriately medicated. The patient was not reassessed within 2 hours as required by protocol.

h. On 01/23/23 at 8:18 PM, the patient was assessed and received a CIWA score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given).

i. On 01/24/23 at 1:30 AM, the patient was assessed and received a CIWA score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given).

j. On 01/24/23, the patient was not assessed at 8:00 AM as required by provider orders (routine CIWA assessments every 6 hours). Eventually, the patient was assessed at 9:52 AM, (1 hours and 52 minutes late) and received a CIWA score of 1.

k. On 01/24/23 at 5:59 PM, the patient was assessed (1 hour and 40 minutes late) and received a CIWA score of 10 and was appropriately medicated.

l. On 01/24/23 at 9:18 PM, the patient was assessed (1 hour and 16 minutes late) and received a CIWA score of 10 and was appropriately medicated. The patient was not assessed within 2 hours as required by protocol.

m. On 01/25/23, the patient was not assessed at 2:00 AM as required by provider orders (routine CIWA assessments every 6 hours).

n. On 01/25/23 at 10:11 AM (2 hours and 11

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L1375	Continued From page 34	L1375		

minutes late), the patient was assessed and received a CIWA score of 8 and was given lorazepam 2 mg by mouth which is outside of the provider orders (a score greater than 8 is required for medication to be given).

o. On 01/25/23 at 2:44 PM and at 5:31 PM, the patient was assessed and received a CIWA score of 9 and no medication was given although indicated by provider orders.

4. On 01/26/23 at 5:00 PM, Surveyor #3 reviewed the medical record of Patient #308 who was admitted for treatment of alcohol dependence. The review showed:

a. Staff failed to perform 4 reassessments after administering medications for elevated CIWA scores .

b. On 08/07/23 at 1:34 AM, the patient was assessed and received a CIWA score of 8 and was given lorazepam 2 mg by mouth which was outside of the provider orders (a score greater than 8 is required for medication to be given).

c. On 08/07/23 at 4:04 PM, the patient was given lorazepam 2 mg by mouth without a documented CIWA score recorded.

5. On 01/27/23 at 10:00 AM, Surveyor #3 reviewed the medical record of Patient #312 who was admitted for treatment of alcohol dependence. The review showed:

a. Staff failed to perform 12 reassessments after administering medications for elevated CIWA scores .

b. Staff failed to perform 4 required scheduled

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L1375	Continued From page 35 CIWA assessments. c. Staff performed required scheduled CIWA assessments late on 2 occasions (ranging from 1 hour and 31 minutes to 3 hours and 8 minutes). d. Staff administered medications on 3 occasions where CIWA scores were 8 or below and did not indicate a need. 6. On 01/30/23 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #313 who was admitted for treatment of alcohol dependence. The review showed: a. Staff failed to perform 17 reassessments after administering medications for elevated CIWA scores. b. Staff failed to perform 1 required scheduled CIWA assessment. c. Staff performed required scheduled CIWA assessments late on 3 occasions. d. Staff did not administer medications on 2 occasions where CIWA scores were greater than 8 (Score of 17 and 9 respectively). e. Staff administered medications on 1 occasion where CIWA scores were 8 or below and did not indicate a need. 7. On 01/30/23 between 9:00 AM and 11:00 AM, Surveyor #3 interviewed the Infection Preventionist (Staff #301) (assisted with medical records review) and the House Supervisor (Staff #303) about the required CIWA assessments and reassessments. Staff #301 and #303 acknowledged the findings and stated that there	L1375		

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L1375	Continued From page 36 had been a large turnover of nursing staff and that many of the staff were new to the facility.	L1375		

Fire Inspection

PRINTED: 01/27/2023
FORM APPROVED

State of Washington

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S 000	Initial Comments This report is the result of an unannounced Fire and Life Safety state survey conducted at Rainier Springs on 01/25/2023 by a team of representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) health survey teams. The facility has a total of 72 beds and at the time of this survey the census 49. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a II-B construction with exits to grade. TThe facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Nicholas D. Wolden 1823 Baker Way Kelso, WA 98626	S 000		
S 920	NFPA 101 Electrical Equipment Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only	S 920		

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (X6) DATE 3

STATE FORM 6899 X9WX21 If continuation sheet 1 of 3

State of Washington

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S 920	Continued From page 1 used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview on 01/25/2023 between approximately 0800 to 1030 hours the facility failed to restrict the use of extension cords and non-approved power strips	S 920		

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S 920	Continued From page 2 in their facility. This could endanger patients, staff, and visitors in the facility due to the increased fire risk. The findings include: Extension cord found in use in HR office. The above was discussed and acknowledged by the facility staff.	S 920		

Plan of Correction received 03/16/23
Plan of Correction approved 03/16/23
[signature] RN/MN 03/16/2023

Rainer Springs Behavioral Hospital
Plan of Correction for
State Licensing Survey
January 24 – 27 & 30, 2023

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L220	Action Plan: All employee records are being audited by the HRBP to ensure the consent for each employee is being added as a separate document from the acknowledged back screening. WA Watch will be downloaded and added to all personnel records moving forward. This has been completed.	HR Business Partner	3/31/23	QAPI: HR will ensure that all employee records have a signed consent in them regarding criminal background checks. 10 employee record audits will be completed monthly for compliance with policy and the state standards. Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L320 Item #1	Action Plan: • To ensure that patient complaints and grievances are addressed according to the policy the Quality Director has implemented a calling system to assist patients with receiving immediate follow-up. The call system is directly connected to the email system. This will eliminate lost paper and will ensure that grievances and complaints are handled within the restraints of the General Grievance policy. Most weekends the Patient Advocate is working and can address any grievances and/or complaints otherwise the House Supervisor assists the handling of grievances and/or complaints.	DOQ	2/1/23	QAPI: Patient advocate and DOQ will monitor the call and email system daily ensuring that patients receive follow up within 24 hours per policy. Each grievance complaint will be acknowledged via a written letter and a resolution letter within 7 days. If additional time is needed to investigate (i.e., lost belongings) the patient will receive a follow-up letter

	• Corporate has trained the DOQ on grievance acknowledgements, resolution letters, and overall policy.			informing them of the investigation's status. 10 audits will be completed monthly for compliance with policy and the state standards. Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months
L 320 Item #2	Action Plan: • To ensure that patient complaints and grievances are addressed according to the policy the Quality Director has implemented a calling system to assist patients with receiving immediate follow-up. The call system is directly connected to the email system. This will eliminate lost paper and will ensure that grievances and complaints are handled within the General Grievance policy. • Corporate completed the education and training on the acknowledgement letter, resolution letter, logging system and overall policy.	DOQ	2/1/23	QAPI: Patient advocate and DOQ will monitor the call and email system daily ensuring that patients receive follow up within 24 hours per policy. Each grievance complaint will be acknowledged via a written letter and a resolution letter within 7 days. If additional time is needed to investigate (i.e., lost belongings) the patient will receive a follow-up letter informing them of the investigation's status. 10 audits will be completed monthly for compliance with policy and the state standards. Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L 390	Action plan:	DON	3/31/23	QAPI: Education and training of all nursing staff

	• All staff will receive education and trainingby nursing leadership regarding the importance and processes of informing family members and/or emergency contact of the patient being transported to another medical facility. • Nursing staff will ensure they are documenting all contacts (nurse to nurse, provider, family, etc.)			by nursing leadership on the transferring of patients. All staff will be trained by 4/9/23. DON will conduct monthly compliance audits to ensure that documentation notifying family members and/or emergency contacts of patients being transferred to another facility which will be reported to QAPI and the governing board quarterly. 10 medical record audits will be completed monthly for compliance with policy for transferring of patients. Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L 540	Action Plan: • HRBP will ensure that all departments who have staff working directly with patients are up to date on their CPR and First Aid training. HRBP has been working with corporate staff to review all open and closed staff records to ensure all documentation is in the employee files. All current employee files are within compliance.	HR Business Partner	3/31/23	QAPI: HR will ensure that all employee records have their current CPR and First Aid cards. 10 employee record audits will be completed monthly for compliance with policy and the state standards. Compliance with this documentation will be reviewed monthly in quality

				council and quarterly in governing board with a goal of 100% for 4 months. No staff will work without current certification.
L 615	Action Plan: • HRBP will ensure that all onboarding staff have their TB-Mantoux test prior to beginning their employment and that it is conducted annually. HRBP has been working with corporate staff to review all open and closed staff records to ensure all documentation is in the employee files. All current employee files are within compliance.	HR Business Partner	3/1/23	QAPI: HR will ensure that all employee records have their current TB-Mantoux. 10 employee record audits will be completed monthly for compliance with policy and the state standards. Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months. No staff will work without current certification.
L 1145	Action Plan: • All staff will receive education and retraining regarding the use of restraint and seclusion by the CPI Instructors. Staff are provided with this training during NEO, annually, and during the debriefing of the incident. Staff will receive education on when a patient should have hands on restrictive interventions, monitoring of the patient in seclusion to ensure that they are released when patient is safe to be released, and how to elevate the intervention being utilized.	DOQ	3/31/23	QAPI: DOQ will work with the CPI instructors to ensure that employees are conducting restraints and seclusion according to the policy and state standards. 10 audits will be completed monthly for compliance with policy and the state standards. Compliance with this process will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months
L 1165	Action Plan:	DON	3/31/23	QAPI: Education and training of all nursing staff

	• Nursing leadership has worked with nursing staff on ensuring the emergency cart is stocked properly with a functioning defibrillator (AED), AED pads that are not expired, suction equipment, oxygen, airways, intravenous tubing, intravenous fluid, and emergency medication (Narcan). DON has worked with the Director of Pharmacy to ensure that the emergency medications in the emergency carts are not expired and regularly monitor. DON has worked with the nursing team to ensure that the emergency cart is checked daily to ensure all contents are in compliance.			by nursing leadership on emergency cart contents. All staff will be trained by 4/9/23. DON will conduct monthly compliance audits to ensure that the emergency carts are within compliance which will be reported to QAPI and the governing board quarterly. 10 audits will be completed monthly for compliance with ensuring that nothing in the emergency cart is expired and that all contents are in the emergency chart as required. Compliance with this item will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L1260	Action Plan: • The Medical Director will ensure that all verbal or telephone orders are authenticated by providers within the policy and state standards. The Medical Director will conduct weekly audits to ensure that the providers are signing off on their telephone orders within the 24-hour time frame. The Medical Director will discuss this is the next MEC meeting.	Medical Director	3/31/23	QAPI: Medical Director will work to ensure that all verbal or telephone orders are authenticated by the provider within 24 hours in accordance with policy and state standards by conducting weekly audits and discussing this protocol in MEC meetings. Weekly audits will be completed monthly for compliance with policy and the state standards. Compliance with this process will be

				reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months
L1375 Item #1 Patient Identification	Action Plan: All nursing staff will be educated by nursing leadership on: 1. Safe medication administration – General Guidelines policy, highlighting patient identification. 2. Standards of care surrounding duplicate drug therapy 3. Clarifying medication orders.	DON	3/31/23	QAPI: The education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders will be monitored daily in the flash meeting to ensure all staff are educated. If someone had not received the training by 4/9/2023 they will not be able to work the unit until training has been completed. Compliance with this training will be reviewed daily in flash, monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained by 4/9/2023. The New hire orientation will be updated by nursing leadership with the training and will audit for 4 months that all new hire staff

				receive this training with a goal of 100% of new hire nurses receiving the training. Compliance with this update to new hire orientation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained. 20 med pass audits will be completed monthly for compliance with the medication administration-General Guidelines policy, Compliance with this policy will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of med pass audits using two identifiers and bar code scanning for 4 months. 10 medical record audits will be completed monthly for compliance with the documentation of clarifying any orders which need clarification per policy. Compliance with this documentation will be

				reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L1375 Item #2 Duplicate Drug Therapy	Action plan: All nursing staff will be educated by nursing leadership on: • Safe medication administration (Five Rights) – General Guidelines policy, highlighting patient identification. • Standards of care surrounding duplicate drug therapy	DON	3/31/23	QAPI: The education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders will be monitored daily in the flash meeting to ensure all staff are educated. If someone had not received the training by 4/9/2023 they will not be able to work the unit until training has been completed. Compliance with this training will be reviewed daily in flash, monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained by 4/9/2023. The New hire orientation will be updated by nursing leadership with the training and will audit for 4 months

				that all new hire staff receive this training with a goal of 100% of new hire nurses receiving the training. Compliance with this update to new hire orientation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained. 20 med pass audits will be completed monthly for compliance with the medication administration-General Guidelines policy, Compliance with this policy will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of med pass audits using two identifiers and bar code scanning for 4 months. 10 medical record audits will be completed monthly for compliance with the documentation of clarifying any orders which need clarification per policy. Compliance with this

				documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L1375 Item #3 Medication administration outside of provider orders	Action plan: All nursing staff will be educated by nursing leadership on: • Safe medication administration (Five Rights) – General Guidelines policy, highlighting patient identification. • Standards of care surrounding duplicate drug therapy • Revise admission order set to provide clarity on administration frequencies, to provide clarity on linked orders, and to reduce opportunity for nurse discretion.	DON	3/31/23	QAPI: The education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders will be monitored daily in the flash meeting to ensure all staff are educated. If someone had not received the training by 4/9/2023 they will not be able to work the unit until training has been completed. Compliance with this training will be reviewed daily in flash, monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained by 4/9/2023. The New hire orientation will be updated by nursing leadership with the training,

				and we will audit for 4 months that all new hire staff receive this training with a goal of 100% of new hire nurses receiving the training. Compliance with this update to new hire orientation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained. 20 med pass audits will be completed monthly for compliance with the medication administration-General Guidelines policy, Compliance with this policy will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of med pass audits using two identifiers and bar code scanning for 4 months. 10 medical record audits will be completed monthly for compliance with the documentation of clarifying any orders which need clarification per policy.

				Compliance with this documentation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months.
L1375 Item #4 CIWA Assessment and Reassessment	Action plan 4: All nursing staff will be educated by nursing leadership on: • Safe handling of the patient on CIWA-AR protocol	DON	4/15/23	QAPI: The education and training of all nursing staff by nursing leadership on CIWA-AR protocol and documentation/monitoring of the protocol will be monitored daily in the flash meeting to ensure all staff are educated. If someone had not received the training by 4/9/2023 they will not be able to work the unit until training has been completed. Compliance with this training will be reviewed daily in flash, monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained by 4/9/2023. The New hire orientation will be updated by nursing leadership with the training,

				and we will audit for 4 months that all new hire staff receive this training with a goal of 100% of new hire nurses receiving the training. Compliance with this update to new hire orientation will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of nursing staff trained. 30 CIWA protocols will be audited monthly to ensure compliance with the CIWA protocol policy and appropriate documentation after each "as needed" (PRN) medication intervention. For each instance of noncompliance, individual education will be provided by nursing leadership. Compliance with the CIWA protocol will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% of hard stops working for 4 months.

APPROVED
By Kimberly Bloor at 9:16 am, Mar 13, 2023

S920	Action Plan: The EOC Director secured the extension cord in the HR office the day of the fire inspection. The EOC Director has provided ongoing training and awareness to all staff regarding the importance of not having extension or power strips within their vicinity. The EOC Director provides this training in New Hire Orientation and annually.	EOC	1/27/23	QAPI: The EOC Director will continue to ensure that there are no extensions or power cords in any vicinity of the hospital. The EOC Director conducts weekly walk throughs of the interior and exterior of the facility ensuring the facility maintains compliance. Weekly walkthroughs will be completed in accordance with state and federal compliance standards and reported during daily Flash meetings. Compliance with this process will be reviewed monthly in quality council and quarterly in governing board with a goal of 100% for 4 months

2nd progress report received 06/28/23

2nd progress report approved 07/03/23 Pam Lest RN, MSN 7/3/23

Rainer Springs Behavioral Hospital
Progress Report for
State Licensing Survey
January 24-27 & 30th, 2023

Tag Number	How Corrected	Date Completed	Results of Monitoring
L220	Action Plan: All employee records are being audited by the HRBP to ensure the consent for each employee is being added as a separate document from the acknowledged back screening. WA Watch will be downloaded and added to all personnel records moving forward. This has been completed.	3/31/23	All new hires files are audited within 30 days and 10 random employee record audits have been completed monthly for compliance with policy and the state standards. Compliance with this documentation has been reviewed during quality committee and leadership meetings. There were 6 New Hires in Feb., 7 New Hires in March, and 18 New Hires in April. All these employee records have been audited and have a compliance rate of 100%. 30 employee charts were completed as well with a 100% compliance rate. There were 8 New Hires in May and 14 in June. All these employee records have been audited with a compliance rate of 100%. All employee files were audited during the months of May and June with a compliance rate of 100%.
L320 Item #1	Action Plan: To ensure that patient complaints and grievances are addressed according to the policy the Quality Director has implemented a calling system to assist patients with receiving immediate follow-up. The call system is directly connected to the email system. This will eliminate lost paper and will ensure that grievances and complaints are handled within the restraints of the General Grievance policy. Most weekends the Patient Advocate is working and can address any grievances and/or complaints otherwise the House Supervisor	2/1/23	Patient advocate and DOQ have been monitoring the call and email system daily ensuring that patients receive follow up within 24 hours per policy. Each grievance received by the patient has received a written acknowledgement of their grievance. A 7 day follow up (resolution letter) letter has been provided to the patients with the grievance. If additional time is needed to investigate (i.e., lost belongings) the patient has received a follow-up letter informing them of the investigation's status. The grievances have been discussed in the quality committee meeting as well in the weekly leadership meetings and daily leadership huddles. Training has been conducted and completed by corporate. In February there were 5 grievances, 6 for March, and 7 for April. All but one has the acknowledgement letter and 7 day follow up letters attached. The one does not have an address to send the follow up letter to. Compliance is 95%.

	assists the handling of grievances and/or complaints. Corporate has trained the DOQ on grievance acknowledgements, resolution letters, and overall policy.		In May there were 9 grievances. 7 out of the 9 received a follow-up letter due to not having an address on file. Compliance is 78% as follow-up letters could not be sent. .
L320 Item #2	Action Plan: To ensure that patient complaints and grievances are addressed according to the policy the Quality Director has implemented a calling system to assist patients with receiving immediate follow-up. The call system is directly connected to the email system. This will eliminate lost paper and will ensure that grievances and complaints are handled within the General Grievance policy. Corporate completed the education and training on the acknowledgement letter, resolution letter, logging system and overall policy.	2/1/23	Patient advocate and DOQ have been monitoring the call and email system daily ensuring that patients receive follow up within 24 hours per policy. Each grievance received by the patient has received a written acknowledgement of their grievance. A 7 day follow up (resolution letter) letter has been provided to the patients with the grievance. If additional time is needed to investigate (i.e., lost belongings) the patient has received a follow-up letter informing them of the investigation's status. The grievances have been discussed in the quality committee meeting as well in the weekly leadership meetings and daily leadership huddles. Training has been conducted and completed by corporate. In February there were 5 grievances, 6 for March, and 7 for April. All but one has the acknowledgement letter and 7 day follow up letters attached. The one does not have an address to send the follow up letter to. Compliance is 95%. In May there were 9 grievances. 7 out of the 9 received a follow-up letter due to not having an address on file. Compliance is 78% as follow-up letters could not be sent.
L390	Action plan: All staff will receive education and training by nursing leadership regarding the importance and processes of informing family members and/or emergency contact of the patient being transported to another medical facility. Nursing staff will ensure they are documenting all contacts (nurse to nurse, provider, family, etc.)	3/31/23	Education and training of all nursing staff by nursing leadership on the transferring of patients has been completed with all staff. DON has conducted at least 10 monthly compliance audits to ensure that documentation notifying family members and/or emergency contacts of patients being transferred to another facility are being completed as required. This information is reported to QAPI and the governing board quarterly. 11 audits were completed in Feb. with a 44% compliance rate. 2 families were contacted. 2 patients did not have emergency contacts and 2 were not admitted; they were sent out from assessment and never returned. 13 audits were completed in March with a 69% compliance rate. 4 families were not notified of the transfer.

			20 audits were completed in April with a 80% compliance rate. 2 families were not notified of the transfer. There were 19 patients transferred to another facility. All patients with an emergency contact listed and approval to contact them were notified of the transfer. 19 charts audited with a 100% compliance rate.
L540	Action Plan: HRBP will ensure that all departments who have staff working directly with patients are up to date on their CPR and First Aid training. HRBP has been working with corporate staff to review all open and closed staff records to ensure all documentation is in the employee files. All current employee files are within compliance.	03/31/2023	All new hires files are audited within 30 days and 10 random employee record audits have been completed monthly for compliance with policy and the state standards. HRBP has ensured that all staff have the required training prior to their shift assignments and has ensured all current employees are following their training requirements. Employees have been removed from the schedule until they are following their required training. Compliance with this documentation has been reviewed during quality committee and leadership meetings. There were 6 New Hires in Feb., 7 New Hires in March, and 18 New Hires in April. All these employee records have been audited and have a compliance rate of 100%. 30 employee charts were completed as well with a 100% compliance rate. There were 8 New Hires in May and 14 in June. All these employee records have been audited with a compliance rate of 100%. All employee files were audited during the months of May and June with a compliance rate of 100%.
L615	Action Plan: HRBP will ensure that all onboarding staff have their TB-Mantoux test prior to beginning their employment and that it is conducted annually. HRBP has been working with corporate staff to review all open and closed staff records to ensure all documentation is in the employee files. All current employee files are within compliance.	03/31/2023	All new hires files are audited within 30 days and 10 random employee record audits have been completed monthly for compliance with policy and the state standards. HRBP has ensured that all staff have the required training prior to their shift assignments and has ensured all current employees are following their training requirements. Employees have been removed from the schedule until they are following their required training. Compliance with this documentation has been reviewed during quality committee and leadership meetings. There were 6 New Hires in Feb., 7 New Hires in March, and 18 New Hires in April. All these employee records have been audited and have a compliance rate of 100%. 30 employee charts were completed as well with a 100% compliance rate.

L1145	Action Plan: All staff will receive education and retraining regarding the use of restraint and seclusion by the CPI Instructors. Staff are provided with this training during NEO, annually, and during the debriefing of the incident. Staff will receive education on when a patient should have hands on restrictive interventions, monitoring of the patient in seclusion to ensure that they are released when patient is safe to be released, and how to elevate the intervention being utilized.	3/31/23	DOQ has worked with the CPI instructors to ensure that employees are conducting restraints and seclusion according to the policy and state standards. New Hire Orientation training has been modified to ensure that all employees understand the policy and procedures surrounding restraints and seclusions. Each incident of a patient being placed in a therapeutic hold or placed in seclusion is reviewed in daily huddles, weekly leadership meetings, and monthly quarterly meetings. Leadership has audited @ least 10 charts per month to ensure compliance with this policy and rule set. All annual review participants and new hires were trained during this review period with a compliance rate of 100%. DOQ has conducted debriefings after a restraint/seclusion incident; reviewing the video content with the staff present and what could have been done differently (if anything). There were 8 incidents reviewed in Feb., 4 in March, and 6 in April. Additional video review of nonrestrictive interventions were reviewed to ensure there were 10 audit reviews per month. There were 5 incidents reviewed in the Month of May. 12 additional video reviews were completed to review nonrestrictive interventions as well.
L1165	Action Plan: Nursing leadership has worked with nursing staff on ensuring the emergency cart is stocked properly with a functioning defibrillator (AED), AED pads that are not expired, suction equipment, oxygen, airways, intravenous tubing, intravenous fluid, and emergency medication (Narcan). DON has worked with the Director of Pharmacy to ensure that the emergency medications in the emergency carts are not expired and regularly monitor. DON has worked with the nursing team to ensure that the emergency cart is checked daily	3/31/23	Education and training of all nursing staff by nursing leadership on emergency cart contents has been conducted. All staff have been trained. DON has conducted monthly compliance audits to ensure that the emergency carts are within compliance and reports out this information during quality committee monthly. During weekly leadership rounding the emergency carts are checked to ensure compliance with this standard. Nursing leadership has conducted 10 audits per month of the emergency cart ensuring it is stocked accordingly and correctly. The compliance rate for this finding is 100%. Nursing leadership has conducted nightly audits on the emergency cart ensuring it is stocked accordingly and correctly. The compliance rate for this finding is 100% as everything is present in the chart and that there are no items in the cart expired.

	to ensure all contents are in compliance.		
L1260	Action Plan: The Medical Director will ensure that all verbal or telephone orders are authenticated by providers within the policy and state standards. The Medical Director will conduct weekly audits to ensure that the providers are signing off on their telephone orders within the 24-hour time frame. The Medical Director will discuss this is the next MEC meeting.	3/31/23	The Medical Director has ensured that all verbal or telephone orders are authenticated by the provider within 24 hours in accordance with policy and state standards by conducting weekly audits and discussing this protocol in MEC meetings. Compliance with this process will be reviewed monthly in quality committee meetings and weekly in leadership meetings. The compliance rate for this finding is 50%. The Medical Director is working with the providers on ensuring they are following the above protocols. The compliance rate for this finding has improved to 60%. The Medical Director continue to work with providers on ensuring they are following the above protocols.
L1375 Item #1 Patient Identification	Action Plan: All nursing staff will be educated by nursing leadership on: • Safe medication administration – General Guidelines policy, highlighting patient identification. • Standards of care surrounding duplicate drug therapy • Clarifying medication orders.	3/31/23	Education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders has been completed with all staff. The New hire orientation has been updated by nursing leadership and was implemented in compliance with this standard. DON has been monitoring this by conducting med passes and chart audits. Compliance with this standard is reviewed daily in the flash meeting, weekly in leadership meetings, and monthly in quality committee. There were 18 med pass audits completed in March and 20 completed in April. There is a 100% compliance rate. There were 15 med pass audits completed in May with a 100% compliance rate.
L1375 Item #2 Duplicate Drug Therapy	Action plan: All nursing staff will be educated by nursing leadership on: • Safe medication administration (Five Rights)	3/31/23	Education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders has been completed with all staff.

	– General Guidelines policy, highlighting patient identification. • Standards of care surrounding duplicate drug therapy		An update to the pyxis system has been completed with a hard stop for medications not to exceed the prescribed doses. The New hire orientation has been updated by nursing leadership and was implemented in compliance with this standard. DON has been monitoring this by conducting med passes and chart audits. Compliance with this standard is reviewed daily in the flash meeting, weekly in leadership meetings, and monthly in quality committee. There were 18 med pass audits completed in March and 20 completed in April. There is a 100% compliance rate. There were 15 med pass audits completed in May with a 100% compliance rate.
L1375 Item #3 Medication administration outside of provider orders	Action plan: All nursing staff will be educated by nursing leadership on: • Safe medication administration (Five Rights) – General Guidelines policy, highlighting patient identification. • Standards of care surrounding duplicate drug therapy • Revise admission order set to provide clarity on administration frequencies, to provide clarity on linked orders, and to reduce opportunity for nurse discretion.	3/31/23	Education and training of all nursing staff by nursing leadership on safe medication administration, therapeutic duplication, and clarifying medication orders has been completed with all staff. An update to the pyxis system has been completed with a hard stop for medications not to exceed the prescribed doses. The New hire orientation has been updated by nursing leadership and was implemented in compliance with this standard. DON has been monitoring this by conducting med passes and chart audits. Compliance with this standard is reviewed daily in the flash meeting, weekly in leadership meetings, and monthly in quality committee. There were 18 med pass audits completed in March and 20 completed in April. There is a 100% compliance rate. There were 15 med pass audits completed in May with a 100% compliance rate.
L1375 Item #4 CIWA Assessment and Reassessment	Action plan 4: All nursing staff will be educated by nursing leadership on: Safe handling of the patient on CIWA-AR protocol	3/31/23	Education and training of all nursing staff by nursing leadership on safe handling of patients' CIWA-AR has been completed with all staff. A retraining was also conducted due to some staff's compliance with this standard. The New hire orientation has been updated by nursing leadership and was implemented in compliance with this standard.

			DON has been monitoring this by conducting med passes and chart audits. Compliance with this standard is reviewed daily in the flash meeting, weekly in leadership meetings, and monthly in quality committee. 40 CIWAR audits were completed in March with a compliance rate of 22% and 40 for April 17% compliance. Staff are being retrained on this process. 40 CIWAR audits were completed in May with a compliance rate of 89%. The new nursing leadership have retrained all staff in CIWAR. The new nursing leadership conducted additional chart audits in April which brought the compliance rate up from 17% to 88%.
S920	Action Plan: The EOC Director secured the extension cord in the HR office the day of the fire inspection. The EOC Director has provided ongoing training and awareness to all staff regarding the importance of not having extension or power strips within their vicinity. The EOC Director provides this training in New Hire Orientation and annually.	1/27/23	The EOC Director has continued to ensure that there are no extensions or power cords in any vicinity of the hospital. The EOC Director continues to conduct weekly walk throughs of the interior and exterior of the facility ensuring the facility maintains compliance. This is 100% compliance as the EOC Director daily checks. May compliance is 100% as the EOC Director conducts daily checks.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

February 23, 2023

Ms. Laverne Adams
Director of Quality
Rainer Springs Behavioral Hospital
2805 NE 129th St
Vancouver, WA 98686

Dear Ms. Adams,

This letter contains information regarding the recent survey of Rainer Springs Behavioral Hospital by the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau. Your state licensing survey was completed on January 30, 2023.

During the survey, deficient practice was found in the areas listed on the attached Statements of Deficiencies (CMS 2567). A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 days after you receive this letter. All corrections for the **Health survey** findings must be completed within **60 days** of the survey exit date (**March 31, 2023**) and **Fire Life Safety** findings must be completed within **35 days** of the survey exit date (**March 6, 2023**).

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;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring procedure including time frame, number of planned observations and the target for compliance.

A sample Plan of Correction has been enclosed for reference. You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return a scanned copy of the original reports and Plans of Correction to me at the following address:

paul.kondrat@doh.wa.gov

If more than 60 days for Health and/or Fire Life Safety corrections are required, the hospital must request an **extension/waiver**. The extension/waiver request must include the facility name; Medicare provider number and/or State license number, date of inspection; citation number; description of deficiency; description of circumstances that will not allow you to meet current deadlines; revised date of when you expect to correct the deficiency; timetable of events leading to correction (i.e. new equipment receive date, new equipment install date etc.); and steps you will take to mitigate risk to patients while the deficiency is being corrected.

Requests for extensions/waivers must be submitted to the undersigned.

Please contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plans of Correction. I may be reached at (360) 236 – 2911. I am also available by email.

I want to extend another "thank you" to you and to everyone that assisted us during the survey.

Sincerely,

Paul Kondrat

Paul Kondrat, MN, MHA, RN
Survey Team Leader

Enclosures: DOH Statement of Deficiencies
WSP Fire Inspection Report
Sample Plan of Correction

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

March 17, 2023

Ms. Laverne Adams
Director of Quality
Rainer Springs Behavioral Hospital
2805 NE 129th St
Vancouver, WA 98686

Dear Ms. Adams,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Rainer Springs Behavioral Hospital on 01/24/23 to 01/27/23 & 01/30/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on March 16, 2023.

A Progress Report is due on or before **April 30, 2023** 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 electronically this progress report to me at the following email address:

paul.kondrat@doh.wa.gov

Please contact me if you have any questions. I may be reached at (360) 236 - 2911. I am also available by email.

Sincerely,

Paul Kondrat

Paul Kondrat, RN, MN, MHA
Survey Team Leader

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

July 3, 2023

Ms. Laverne Adams
Director of Quality
Rainer Springs Behavioral Hospital
2805 NE 129th St
Vancouver, WA 98686

Dear Ms. Adams,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Rainer Springs Behavioral Hospital on 01/24/23 – 01/27/23 and 01/30/23, 2023. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on March 16, 2023.

Hospital staff members sent a 2nd Progress Report dated June 28, 2023 that indicates all deficiencies have been corrected. The Department of Health accepts Rainer Springs Behavioral Hospital's attestation to be in compliance with Chapter 246-322 WAC.

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,

Paul Kondrat

Paul Kondrat, RN, MN, MHA
Survey Team Leader