State of Washington

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--|---|-------------------------|---|-------------------------------|
|  |   |                         |   | С                             |
|  | 013319  | B. WNG                  |   | 12/06/2023                    |
| NAME OF PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, ST        | ATE, ZIP CODE   |                               |
| SOUTH SOUND BEHAVIORAL H   | OSPITAL   | DDLAND SQUA<br>WA 98503 | RE LOOP SE  |                               |
| PREFIX (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)               | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)  | BE COMPLETE                   |
| L 000 INITIAL COMMENT  | S   | L 000                   |   | -                             |
| (DOH), in accordance Administrative Code Psychiatric and Alcordance this complaint inves  On-site dates: 12/04 Case number: 2023 Intake number: 1329 | ate Department of Health ce with Washington (WAC), 246-322 Private sholism Hospitals, conducted tigation. |                         | 1. A written PLAN OF CORRECTION required for each deficiency listed on a 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 monito continued compliance; and  WHEN the correction will be complete  3. Your PLAN OF CORRECTION mus returned within 10 calendar days from date you receive the Statement of Deficiencies. Your Plan of Correction is due on 12/31/23.  4. Return the ORIGINAL REPORT via email with the required signatures. | r for<br>d.<br>t be<br>the    |
| L 365 322-035.1M POLICI  | ES-PATIENT PROPERTY   | L 365                   |   |                               |
| WAC 246-322-035 F<br>Procedures. (1) The<br>develop and implem<br>written policies and<br>consistent with this of<br>State Form 2567                 | licensee shall<br>ent the following<br>procedures   |                         |   |                               |

(X6) DATE

State of Washington

|               | FOF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:        |                    | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|---------------|-----------------------------------|---|--------------------|---|-------------------------------|
|               |                                   |   |                    |   | C                             |
|               |                                   | 013319  | B. WING            |   | 12/06/2023                    |
| NAME OF D     | ROVIDER OR SUPPLIER               | STDEET A  | DDRESS, CITY, STAT | TE ZIP CODE   |                               |
| TOTAL OF T    | NOVIDEN ON BOI I EIEN             |   | DDLAND SQUARI      |   |                               |
| SOUTH S       | OUND BEHAVIORAL HO                | SPITAL.   | WA 98503           | 2 2001 02   |                               |
| (X4) ID       | SUMMARY STA                       | ATEMENT OF DEFICIENCIES                                   | ID                 | PROVIDER'S PLAN OF CORRECTION   | N (X5)                        |
| PREFIX<br>TAG |                                   | Y MUST BE PRECEDED BY FULL<br>SC (DENTIFYING INFORMATION) | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | BE COMPLETE                   |
| L 365         | Continued From page               | <del>2</del> 1  | L 365              |   |                               |
| -             | services provided: (m             | ) Responsibility  |                    |   |                               |
|               | for patients' personal            |   |                    |   |                               |
|               | including recording ar            |   |                    |   |                               |
|               | on deposit with the ho            | •   |                    |   |                               |
|               | This Washington Adm               | ninistrative Code is not met                              |                    |   |                               |
|               | as evidenced by:                  |   |                    |   |                               |
|               | Based on interview r              | ecord review, and review of                               | ***                |   |                               |
|               | the hospital's policies           |   |                    |   |                               |
|               |                                   | re that patients' personal                                |                    |   |                               |
|               |                                   | during their stay for 4 of 6                              |                    |   | ·                             |
|               |                                   | atients #1, #2, #4, and #5).                              |                    |   |                               |
|               |                                   |   |                    | •   |                               |
|               |                                   | patient's property is secure                              |                    |   |                               |
|               |                                   | ay may result in patients                                 |                    |   |                               |
|               |                                   | necessary items, leaving                                  | .                  |   |                               |
|               | patients vulnerable to            |   |                    |   |                               |
|               | money, or weather-su              | mable doming.   |                    |   |                               |
|               | Findings included:                |   |                    |   |                               |
|               | 1. Review of the police           | y titled, "Inventory and                                  |                    |   |                               |
|               |                                   | longings," policy number                                  |                    |   |                               |
|               | #PC004, last reviewe              | d 08/21, showed that staff                                |                    |   |                               |
|               | are required to perfor            |   |                    |   |                               |
|               |                                   | t belongings during the                                   |                    |   |                               |
|               |                                   | Vhenever possible, the                                    |                    |   |                               |
|               |                                   | sent during the process.                                  |                    |   |                               |
|               |                                   | atient and the staff member                               |                    |   |                               |
|               |                                   | ory will sign and date the                                |                    |   |                               |
|               | Inventory of Patient B            | articipate, two staff members                             |                    |   |                               |
|               |                                   | entory process and sign the                               |                    |   |                               |
|               |                                   | e inventoried and listed                                  |                    |   |                               |
|               | 1                                 | entory of Patient Belongings                              |                    |   |                               |
|               | 1 -                               | d. The document is then                                   |                    |   |                               |
|               | 1                                 | ge planning section of the                                |                    |   |                               |
|               |                                   | ent is discharged, a Mental                               |                    |   |                               |
|               |                                   | HT) collects the patient's                                |                    |   |                               |
|               | belongings and inven              | tories them again in the                                  |                    |   |                               |

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STATEMENT OF DEFICIENCIES

| STATEMEN      | T OF DEFICIENCIES<br>OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:        |                  | E CONSTRUCTION   | (X3) DATE S<br>COMPL |                  |
|---------------|--|--|------------------|--|----------------------|------------------|
|               |  | 013319   | B. WING          |  | 4000                 |                  |
| NAME OF P     | ROVIDER OR SUPPLIER  |  | PRESS, CITY, STA | ATE, ZIP CODE  | 12/0                 | )6/2023          |
| SOUTH S       | OUND BEHAVIORAL HO   | SPITAL   | LAND SQUAR       | RE LOOP SE   |                      |                  |
| (X4) ID       | SUMMARY STA  | LACEY, WATEMENT OF DEFICIENCIES                              | N 96503          | PROVIDER'S PLAN OF CORRECTION  | J                    | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)    | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                   | COMPLETE<br>DATE |
| L 365         | Continued From page  | 2  | L 365            |  |                      |                  |
|               |  | nt. Both the MHT and the                                     |                  |  |                      |                  |
|               | patient sign the docur<br>patient received their                   | nent again to show that the items                            |                  |  |                      |                  |
|               | •  |  |                  |  |                      |                  |
|               |  | 0 PM, an interview with a<br>I) (Staff #1) showed that       |                  |  |                      |                  |
|               | during the admission   | process, patient belongings                                  |                  |  |                      |                  |
|               |  | umented on the Inventory of<br>rm, including the contents of |                  |  |                      |                  |
|               | wallets.   |  |                  |  |                      |                  |
|               | 3. On 12/06/23 at 2:45   | 5 PM, an interview with an                                   |                  |  |                      |                  |
|               |  | d that staff should complete<br>nt Belongings form for every |                  |  |                      |                  |
|               |  | nission process, even if they                                |                  |  |                      |                  |
|               |  | onal belongings with them. If<br>m an acute care Emergency   |                  |  |                      |                  |
|               | Department (ED) with   | out any personal   |                  |  |                      |                  |
|               | belongings, staff will on patient had items that                   | all the ED to find out if the                                |                  |  |                      |                  |
|               | discharge.   | Word not rotal flow at                                       |                  |  |                      |                  |
|               | 4. The investigator rev  | viewed the medical records                                   |                  |  |                      |                  |
|               | of 6 patients admitted   | to the facility between                                      |                  |  |                      |                  |
|               | 06/13/22 and 11/07/23 following:                                   | 3. The review showed the                                     |                  |  |                      |                  |
|               | _  | 30. de de 7 99   |                  |  |                      |                  |
|               | <ul><li>a. Patient #1 was adm<br/>06/13/22 and discharge</li></ul> | ged on 09/27/22. A review of                                 |                  |  |                      |                  |
|               | the Inventory of Patier  | nt Belongings form showed                                    |                  | ·  |                      |                  |
|               | that Patient #1 signed the facility on 06/14/22                    | the form upon admission to<br>2, and at discharge on         |                  |  |                      |                  |
| İ             | 09/27/22. There were   | no staff signatures on the                                   |                  | ·  |                      |                  |
|               |  | no performed the initial used the belongings to the          |                  |  |                      |                  |
|               | patient as required by   |  |                  |  |                      |                  |
|               | b. Patient #2 was adm  | nitted to the facility on                                    |                  |  |                      | ĺ                |
|               | 09/14/22 and discharg  | jed on 09/23/22. The   |                  |  |                      |                  |
|               | investigator found no  | evidence that staff  |                  |  |                      |                  |

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STATEMENT OF DEFICIENCIES

| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | l ` ′                 | CONSTRUCTION  | (X3) DATE SU<br>COMPLE |                          |
|--------------------------|--|---|-----------------------|---|------------------------|--------------------------|
|                          |  | 013319  | B. WING               |   | C<br>12/06             | 6/2023                   |
| NAME OF P                | ROVIDER OR SUPPLIER  | 1. ju je je   | RESS, CITY, STA       | TE, ZIP CODE  | 1 12.0                 | <u></u>                  |
| SOUTH S                  | OUND BEHAVIORAL HO   | SPITAL 605 WOOD<br>LACEY, WA  | LAND SQUAR<br>\ 98503 | E LOOP SE   |                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                     | (X5)<br>COMPLETE<br>DATE |
| L 365                    | completed an Inventor form at any time durin hospitalization as required. Patient #4 was add 11/14/22 and dischard Inventory of Patient Ethe patient had "cloth admission. Staff failed list of patient belonging signature showing why patient at discharge, apolicy.  d. Patient #5 was add 11/07/23. A review of Belongings form, date itemized list of patien no patient or staff signospital policy.  5. On 12/06/23 at 5:2 Chief Executive Official if a patient is admitted belongings, there should be the patient did not the patient | ary of Patient Belongings and Patient #2's uired by hospital policy.  mitted to the facility on ged on 11/21/22. The selongings form showed that es and hoodies" on at to document an itemized and an another was no staff and returned the items to the as required by hospital witted to the facility on the Inventory of Patient ed 11/08/23, showed and to belongings, but there were matures as required by  5 PM, an interview with the err (CEO) (Staff #7) showed and without any personal and be documentation on the Belongings form to show of have belongings. During of confirmed the investigator's great documentation for | L 365                 |   |                        |                          |
| L1080                    | 322-170.2H DISCHA WAC 246-322-170 f Services. (2) The lice provide medical supe treatment, transfer, a planning for each pat   | Patient Care<br>nsee shall<br>rvision and<br>nd discharge   | L1080                 |   |                        |                          |

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FORM APPROVED State of Washington (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ С 013319 12/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) L1080 Continued From page 4 L1080 retained, including but not limited to: (h) A discharge plan including a review of the patient's hospitalization, condition upon discharge, and recommendations for follow-up and continuing care; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that patients with suicidal ideation met the criteria for discharge for 1 of 6 patient records reviewed (Patient #2) (item #1), and the hospital failed to adopt and implement policies and procedures to ensure an appropriate discharge plan for 2 of 4 patients with access to firearms (Patients #2 and #3) (item #2). Failure to ensure that patients with suicidal ideation meet the criteria for discharge, and failure to adopt and implement policies and procedures to ensure that patients with access to firearms receive an appropriate discharge plan places patients and the community at risk of serious physical and psychological harm, including death. Item #1: Discharge Criteria 1. Review of the policy titled, "Admission, Discharge, and Continued Stay Criteria," policy number #PC005, last revised 04/22, showed that discharge criteria include reaching the goals of treatment at the current level of care, having follow up goals and a treatment plan for lesser levels of care, and that releasing the patient to a

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lesser level of care will not pose a threat to the

patient, others, or property.

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risk in a patient as a positive finding, indicating that the patient will be treated as a suicide risk until further assessment shows that the suicide

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to be addressed in the next level of care and identify the individual(s) responsible for ensuring that the prescribed follow-up is accomplished.

2. On 12/06/23 at 3:15 PM, an interview with the Director of A&R (Staff #6) showed that all patients initially start their stay with Q5 observations (visualizing the patient every 5 minutes to assess safety). A&R treats the inability to assess suicide

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING 013319 12/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L1080 Continued From page 6 L1080 risk is resolved. Staff #6 stated that at discharge, staff members consider existing supports and resources when assessing suicide risk. On 12/06/23 at 4:30 PM, an interview with a Discharge Planner (Staff #4) showed that any suicidal ideation identified at discharge is reported to the provider to see what the provider wants to do. Staff #4 stated that discharge can be canceled if a patient presents with suicidal ideation at the time of discharge. 4. On 12/06/23 at 2:00 PM, an interview with an Advanced Registered Nurse Practitioner (ARNP) (Staff #5) showed that suicidal ideation at discharge is not always exclusionary and is determined on a case-by-case basis. Staff #5 stated that the provider looks at family support and any history of chronic suicidal ideation to identify protective factors for suicide risk at discharge. Staff #5 stated that suicide precautions need to be discontinued before the patient can be discharged. 5. Review of the medical record showed that Patient #2 was a 52-year-old man voluntarily admitted on 09/14/22 for suicidal ideation, depression, severe alcohol use, and complicated grief after recently losing his son to suicide. Review of the patient's Master Treatment Plan, dated 09/15/22, showed that the patient should exhibit no suicidal ideation for 48 hours prior to discharge. The area of the Treatment Plan

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showing that an identified goal was attained, revised, canceled, or continued was blank, and there was no documented resolution of any problems or achievement of any goals prior to

discharge. The investigator found no documentation showing the goal was met, revised, or canceled at anytime prior to Patient

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precautions or Q5 observations before the patient

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

was discharged.

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guns.

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

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

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following:

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

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|                          | FOF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                   | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|----------------------------|
|                          | •   |  |                     |   | С                          |
|                          |   | 013319   | B. WNG              |   | 12/06/2023                 |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, STA    | ATE, ZIP CODE   |                            |
| COUTHE                   | OURD DELLAWORAL HOL   | 605 WOO  | DLAND SQUAF         | RE LOOP SE  |                            |
| SUU1H SI                 | OUND BEHAVIORAL HOS   | LACEY, W   | /A 98503            |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETE                |
| L1080                    | Continued From page   | 10   | L1080               |   |                            |
|                          | his deceased son's he suicide multiple times Transition Plan, dated patient was asked if the The documentation showed having guns in the hort that the patient denied There was no docume gun referenced in the removed or secured.  b. Patient #3 was a 43 voluntarily on 09/19/22 Disorder (PTSD) and previous military deplot The Intake Assessment that the hospital A&R had access to guns are suicide attempts. The marked "yes" to both to the side of the chector both questions. The explaining the discrep Transition Plan, dated Patient #3 denied hav There was no docume asked the patient about the intake document adocument. The Disched dated 09/24/22, showe having guns in the horshowed that staff asket. | ouse and had attempted. The Discharge and 109/23/22, showed that the nere were guns in the home. Howed that the patient at the home. The ad that Patient #2 denied me, and staff documented at having access to guns. Interest the intake document was a sentation showing that the sentation related to her payment and combat status. Int., dated 09/19/22, showed staff asked the patient if she and if she had any history of document showed that staff questions; in the text boxes of the skew was no documentation ancy. The Discharge and 09/24/22, showed that ing guns in the home. Sentation showing that staff ut the discrepancy between |                     |   |                            |
|                          |   |  |                     |   |                            |
|                          | about the modification  | Sourcon and made and   | 1                   |   |                            |

State Form 2567 STATE FORM

PRINTED: 12/21/2023 FORM APPROVED

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ С B. WING\_ 013319 12/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 605 WOODLAND SQUARE LOOP SE SOUTH SOUND BEHAVIORAL HOSPITAL **LACEY, WA 98503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1080 Continued From page 11 L1080 discharge documents. During the interview, Staff #7 stated that the intake question asks about the patient's access to guns or any lethal means, and the discharge question asks specifically about guns in the patient's home. During the interview, Staff #7 confirmed the investigator's findings that the questions were worded differently and stated that he could see how the inconsistency could led to the omission of information about a patient's access to guns outside of the home. 12/27/2023 NEIL LACANIALIÉ, Ed.D, MAN. PMHNP-BC Interim CEO South Sound Behavioral Hospital

State Form 2567

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

Case Number: 2023-9228

| Tag Number   | How the Deficiency Will Be Corrected  | Responsible Individual(s) | Estimated Date of Correction | Monitoring procedure; Target for Compliance                |
|--|---|---------------------------|------------------------------|--|
| L 365 322-035.1M POLICIES-PATIENT PROPERTY   |   |                           |                              | A  |
| WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (m) Responsibility for patients' personal property, including recording any valuables left on deposit with the hospital; This Washington Administrative Code is not met as evidenced by: |   |                           |                              | V  |
| Based on interview, record review, and review of the hospital's policies and procedures, the hospital failed to ensure that patients' personal property was secured during their stay for 4 of 6 patients reviewed (Patients #1,   | South Sound Behavioral Hospital is committed to providing quality care to its patients. With these opportunities for improvement, SSBH team will: |                           |                              |  |
| #2, #4, and #5). Failure to ensure the patient's property is secure during the patient's stay may result in patients losing valuables and necessary items, leaving patients vulnerable to lack of identification, money, or weather-   | <ol> <li>Policy and Procedure on<br/>Inventory and Storage of<br/>Patient Belongings was<br/>reviewed and updated.</li> </ol>                     | Interim CEO               | 12/27/2023                   | Approved revised form, policy & procedure on Inventory and |
| suitable clothing.   | Policy update includes the  | Interim CEO               | 12/27/2023                   | Storage of Patient   |
| Findings included:   | following:<br>Weapons<br>i. The treatment   |                           |                              | Belongings   |
| 1. Review of the policy titled, "Inventory and Storage of  | team will make the  |                           |                              |  |
| Patient Belongings," policy number #PC004, last reviewed   | final decision if   | CNO, A&R                  | 1/19/2023                    | Documented   |
| 08/21, showed that staff are required to perform and   | weapons may be  | Director,                 |                              | attestation to the   |
| document an itemized list of patient belongings during the admission process. Whenever possible, the patient   | returned to the   | Clinical                  |                              | training provided for                                      |
| should be present during the process. When finished, the   | patient.  | Services                  |                              | all admissions &   |
| patient and the staff member completing the inventory  | <ol> <li>Any involuntary</li> </ol>   | Director                  |                              | referral staff and nursing staff. Any                      |
| will sign and date the Inventory of Patient Belongings   | or ITA  |                           |                              | staff member not   |

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

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

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

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

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

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

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

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

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

Submitted by:

NEIL LACANLY LE, Ed.D, MAN, PMHNP-BC Interim Chief Executive Officer

South Sound Behavioral Hospital Date: 12/28/2023

03/05/24

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

Re: Complaint 2023-9228

Dear Mr Lacanlale:

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

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

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

Sincerely,

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