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<tr>
<td>L 000</td>
<td>INITIAL STATE LICENSING SURVEY</td>
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<td></td>
<td>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.</td>
<td></td>
<td>A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.</td>
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<td></td>
<td>Onsite dates: 08/27/18 to 08/28/18</td>
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<td>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 rec occurrence and how you will monitor for continued compliance; and WHEN the correction will be completed.</td>
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<td></td>
<td>Examination number: X2018-692</td>
<td></td>
<td>3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by September 17, 2018.</td>
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<td>The survey was conducted by:</td>
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<td>4. Return the ORIGINAL REPORT with</td>
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<td>Surveyor #3, Surveyor #4</td>
<td></td>
<td>the required signatures</td>
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<td>The Washington Fire Protection Bureau conducted the fire life safety inspection on 08/20/18.</td>
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<td>L 210</td>
<td>322-030.3A BACKGROUND-STAFF</td>
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<td>WAC 246-322-030 Criminal history, disclosure, and background inquiries. (3) The licensee or license applicant shall: (a) Require a Washington state patrol criminal history background inquiry, as specified in RCW 43.43.842 (1), from the Washington state patrol or the department of social and health services for each: (i) Staff person, student, and any other individual</td>
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State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature]

TITLE: [Title]

DOB DATE: [DOB Date]

STATE FORM: [State Form]

PYNX11 [Provider Number]
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>L210</td>
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<td>Currently associated with the hospital having direct contact with vulnerable adults, when engaged on or since July 22, 1999; (i) Prospective staff person, student, and individual applying for association with the hospital prior to allowing the individual direct contact with vulnerable adults, except as allowed by subsection (4) of this section; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to obtain a disclosure statement and background inquiry as defined in RCW 43.43.834 for each prospective employee associated with the hospital having direct contact with vulnerable adults for 5 of 5 personnel files reviewed (Staff #402, Staff #403, Staff #404, Staff #405, and Staff #406) and 3 of 3 physician credentialing files reviewed (Staff #407, Staff #408 and Staff #409). Failure to perform an appropriate background inquiry pursuant to RCW 43.43.834 Child and Adult Abuse Information Act, puts patients at risk of abuse from improperly screened staff and contractors. Reference: RCW 43.43.834. Background checks by business, organization, or insurance company-Limitations-Civil liability.</td>
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(1) A business or organization shall not make an inquiry to the Washington state patrol under RCW 43.43.832 or an equivalent inquiry to a federal law enforcement agency unless the business or organization has notified the applicant who may be offered a position as an employee or
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<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| L 210 | Continued From page 2 volunteer, that an inquiry may be made. (2) A business or organization shall require each applicant to disclose to the business or organization whether the applicant: (a) Has been convicted of a crime; (b) Has had findings made against him or her in any civil adjudicative proceeding as defined in RCW 43.43.830; or (c) Has both a conviction under (a) of this subsection and findings made against him or her under (b) of this subsection. (3) The business or organization shall pay such reasonable fee for the records check as the state patrol may require under RCW 43.43.838. (4) The business or organization shall notify the applicant of the state patrol's response within ten days after receipt by the business or organization. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability. Findings included: 1. Surveyor #4 reviewed 5 personnel files of both credentialed and non-credentialed hospital staff and the credentialing files of 3 physicians. The review showed: Five of 5 personnel files and 3 of 3 credentialing files did not contain a disclosure statement that contained any of the elements described by RCW 43.43.834. Five of 5 personnel files and 3 of 3 credentialing files did not contain a Washington state patrol criminal history background inquiry. 2. On 08/28/18 at 2:30 PM, Surveyor #4 interviewed the hospital's corporate Vice
L 210 Continued From page 3

President of Quality (Staff #401) about the disclosure statement. The staff member stated she was unaware of the specific requirements for disclosure statements and Washington state patrol criminal background checks as described above.

L 305 322-035.1A POLICIES-ADMIT CRITERIA

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: (a) Criteria for admitting and retaining patients;

This Washington Administrative Code is not met as evidenced by:

Based on interview and document review, the hospital failed to establish a written policy and procedure on retaining patients who request discharge when not clinically indicated.

Failure to have a written policy and procedure for retaining patients involuntarily risks staff confusion and delays in taking appropriate actions upon request for discharge.

Findings included:

1. Document review of the hospital's policy titled, "Discharge Against Medical Advice," policy number 5183670, no approval date, showed that if the attending physician declines the patient request to be discharged, the staff will begin the involuntary hold process according to "M-1 Hold, per Colorado state regulation." The policy did not address the steps staff should take to follow the
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<tr>
<td>L 305</td>
<td></td>
<td>Continued From page 4 state of Washington involuntary detention process.</td>
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<td>L 305</td>
<td>2. On 08/28/18 between 1:00 PM and 2:00 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) about the hospital's policy for retaining patients. Staff #301 confirmed the policy submitted to the surveyor failed to refer to the revised code of Washington (RCW) law nor did it address the specific steps staff should take when patients request discharge when it is not clinically indicated nor safe.</td>
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<td>L 370</td>
<td>322-035.1N POLICIES-PATIENT WORK</td>
<td>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; (2) Allowing patients to work on the premises, according to WAC 246-322-180; This Washington Administrative Code is not met as evidenced by: Based on interview and review of the hospital's policies and procedures, the hospital failed to establish an approved written policy and procedure addressing patients working at the facility as part of their treatment plan. Failure to have an approved written policy and procedure risks staff confusion and delay in addressing a patient's request to work on the premises. Findings included:</td>
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<td>L370</td>
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<td>1. Document review of the hospital's policy titled, &quot;Patient Work,&quot; no policy number, showed that the hospital leadership had not approved the policy at the time of review.</td>
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<td>2. On 08/27/18 between 2:00 PM and 5:00 PM, Surveyor #3 reviewed the hospital policies and procedures. An interview with the Director of Quality (Staff #301) confirmed the &quot;Patient Work&quot; policy had not been approved to date.</td>
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<td>L405</td>
<td>322-035.1U POLICIES: CLINICAL RECORDS</td>
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<td>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: (u) Clinical records consistent with WAC 246-322-200, the Uniform Medical Records Act, chapter 70.02 RCW and Title 42 CFR, chapter 1, Part 2, 10/1/88; This Washington Administrative Code is not met as evidenced by:</td>
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<td>Based on interview and document review, the hospital failed to establish a written policy and procedure on clinical records that addressed the time interval required for completion of the comprehensive treatment plan.</td>
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<td>Failure to have a written policy and procedure that addresses when clinical staff will complete the treatment plan puts patients at risk for delayed treatment and care.</td>
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<td>Findings included:</td>
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**L 405** Continued From page 6

1. Document review of the hospital's policy titled, "Treatment Planning - Philosophy and Purpose," policy number 5003822, approved 07/18, showed that care and treatment decisions are made on a collaborative basis with input from all disciplines. The care plan will include patient objectives, staff interventions, services, and treatments necessary to assist the patient in meeting identified care plan goals. The policy did not address the time interval required for completion of the comprehensive treatment plan.

2. On 08/28/18 between 1:00 PM and 2:00 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) about the hospital's policy for treatment planning. Staff #301 confirmed the policy did not address the timeframe in which the clinical staff completes the comprehensive treatment plan.

**L 485**

322-040.8G ADMIN RULES-FUNCTIONS

WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (g) Required functions;

This Washington Administrative Code is not met as evidenced by:

Based on interview and document review, the hospital’s medical staff rules and regulations failed to establish a required time interval for completion of the comprehensive psychiatric evaluation.

Failure to establish medical rules and regulations consistent with the state of Washington clinical
RAINIER SPRINGS
2805 N 129TH ST
VANCOUVER, WA 98686

L 485
Continued From page 7
record requirements puts patients at risk for
delayed care and adverse outcomes.

Findings included:

1. Document review of the Medical Staff Rule and
Regulations titled, "Medical Staff Rules and
Regulations," policy number 4985273, approved
07/18, showed the elements required of a
comprehensive psychiatric evaluation, but did not
address the timeframe for staff to complete the
evaluation.

2. On 08/26/18 between 1:00 PM and 2:00 PM,
Surveyor #3 interviewed the Director of Quality
(Staff #301) about the hospital's medical rules
and regulations. Staff #301 confirmed that the
current medical rules and regulations failed to
address the state of Washington's required
72-hour time interval for completion of a
psychiatric evaluation following the patient's
admission.

L 505
322-050.1A PROVIDE PATIENT SERVICES

WAC 246-322-050 Staff. The licensee
shall: (1) Employ sufficient,
qualified staff to: (a) Provide
adequate patient services;
This Washington Administrative Code is not met as evidenced by:

Based on document review and interview, the
hospital failed to ensure hospital staff had
appropriate Department of Health credentials for
the individual's scope of practice.

Failure to ensure that staff obtained appropriate
credentials for their scope of practice risks patient
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Reference: WAC 246-841-400 - Standards of practice and competencies for nursing assistants. WAC 246-810-015 - Agency affiliated counselor: Scope of practice and credentialing requirements.

Findings included:

1. Document review of the hospital’s job description titled, "Patient Care Assistant (PCA)," showed that the job position was structured under the Nursing Department. Major job responsibilities include tasks delegated by the registered nurse related to the care of the patient including but not limited to vital signs, specimen collection, documentation, group education, and patient monitoring. Other responsibilities include observation and maintenance of a safe milieu through patient checks, safety monitoring, evaluating for changes in patient's condition, and providing line of sight or one-on-one care as directed.

The job description did not include requirements for obtaining of an affiliated agency counselor credential and a nursing assistant credential.

Document review of the hospital policy, "Plan for the Provision of Nursing Care in Psychiatric Specialty Areas," policy number 5096292, approved 08/18, showed that a patient care assistant (PCA) can assist the registered nurse (RN) with delegated tasks. These tasks include obtaining vital signs, assisting with personal care and hygiene of the patient, assisting with meals, providing patient supervision and monitoring patients on their individual prescribed level of observation and when competent, assisting in...
obtaining phlebotomy and lab specimens.

Document review of the hospital policy, "Waived Testing," policy 4190410, approved 11/17, showed that "Glucometer monitoring of pre-existing diabetic conditions and blood sugar abnormalities will be done by the RN or PCA per order of attending and medical provider."

Document review of the Patient Care Assistant Clinical Orientation Checklist showed the following competencies: Obtaining BAC (Blood Alcohol Concentration), Emergency Equipment, Glucometer, Group Skills, HCG (pregnancy test), Vital Signs measurement, Security Wanding, and Urine Drug Screen testing.

2. On 08/26/18, between 1:45 and 2:45 PM, Surveyor #4 reviewed five personnel files of both credentialed and non-credentialed staff. During the review of a Patient Care Assistant/Biomed Technician (Staff #404) file, the review showed that the Washington State Department of Health did not credential the staff member.

3. On 09/07/18 at 9:00 AM, Surveyor #3 interviewed the Director of Quality (Staff #301) about the Patient Care Assistant (PCA) job description. Staff #301 confirmed that the current PCA position did not require individuals to obtain a nursing assistant credential with the Washington State Department of Health.

L 530

322-050.4 WORK REFERENCES

WAC 246-322-050 Staff. The licensee shall: (4) Verify work references prior to hiring staff; This Washington Administrative Code is not met
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<th>(X3) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X3) COMPLETE DATE</th>
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<tr>
<td>L 530</td>
<td>Continued From page 10 as evidenced by: Based on document review and interview, the hospital failed to provide evidence that they verified work references prior to hiring staff, for 2 of 5 personnel files reviewed (Staff #402 and Staff #404). Failure to verify work references prior to hiring staff puts patients at risk of harm from staff that lack competency or training. Findings included: 1. On 08/28/18, between 1:45 and 2:45 PM, Surveyor #4 reviewed 5 personnel files of both credentialed and non-credentialed staff. Initially, the review showed that work references were missing for 4 of 5 files. 2. At the time of the review, the hospital's corporate Vice President of Quality (Staff #401) stated that there were other reference checks completed and was able to provide documentation of work reference checks for 2 additional staff members, but could not find evidence of reference checks for the remaining 2 staff members (Staff #402 and Staff #404).</td>
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<td>L 615</td>
<td>322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WSHA 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 association with the hospital. (a) A</td>
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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 implement policies designed to protect patients from tuberculosis (TB) for 3 of 5 personnel files reviewed (Staff #402, Staff #403, and Staff #405).

Failure to implement policies designed to protect patients from tuberculosis puts patients, visitors and staff at risk of harm from infection.

Findings Included:

1. Document review of the hospital document titled, "Employee Health Questionnaire," effective date 01/01/12, showed that all employees will receive a PPD skin test upon hire unless the employee has had a PPD test conducted within the last year. The policy is non-compliant with the state requirement that employees have a documented skin test no more than six months prior to employment.

2. On 08/28/18, between 1:45 and 2:45 PM,
### L 615
Continued From page 12

Surveyor #4 reviewed 5 personnel files of both credentialed and non-credentialed staff. For 3 of 5 staff members, the review showed their last documented skin test occurred more than one year prior to their hire date.

- a. Nurse Manager (Staff #402), Hire Date: 07/30/18; Last TB skin test: 01/2017
- b. Registered Nurse (Staff #403), Hire Date: 08/27/18, Last TB skin test: 12/2011
- c. Chemical Dependency Therapist (Staff #405), Hire Date: 08/27/18, Last TB skin test: 11/2016

### L 985
322-150.3B EXAM ROOM-LIGHT

WAC 246-322-150 Clinical facilities. The licensee shall provide: (3) One or more physical examination rooms, with or without an exterior window, equipped with: (b) Examination light; This Washington Administrative Code is not met as evidenced by:

Based on observation, the hospital failed to provide an examination light in its patient examination room.

Failure to provide an examination light in a patient examination room puts patients at risk of inadequate care.

Findings included:

1. On 08/27/18 at 11:50 AM, Surveyor #4 toured the "Meadows" unit of the hospital, which included the patient examination room. The
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<td>L1125</td>
<td>322-170.3G RT SERVICES</td>
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322-170.3G RT SERVICES

WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (g) Recreational therapy services coordinated and supervised by a recreational or occupational therapist with experience working with psychiatric patients, responsible for integrating recreational therapy functions into the comprehensive treatment plan;

This Washington Administrative Code is not met as evidenced by:

Based on interview, the hospital failed to ensure that a recreational or occupational therapist coordinated and supervised recreational therapy services.

Failure to have a qualified professional coordinate recreational therapy services places hospital patients at risk for receiving incomplete comprehensive treatment.

Findings included:

1. On 08/28/18 between 1:00 PM and 2:00 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) and the Chief Executive Officer (CEO) (Staff #303) about the hospital recreational program. The surveyor asked who supervised the program. Staff #301 stated that currently, the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
RAINIER SPRINGS

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2805 N 129TH ST
VANCOUVER, WA 98686

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<tr>
<td>L1125</td>
<td>Continued From page 14, program would be coordinated by the Director of Clinical services who is a licensed social worker. The expected hiring of a recreational therapist was not successful. The hospital was exploring an option of bringing a temporary therapist from out of state.</td>
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<td>L1145</td>
<td>322-180.1C RESTRAINT OBSERVATIONS</td>
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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 interview and review of hospital policies and procedures, the hospital failed to establish a written policy and procedure addressing the recording of observations and interventions in the clinical record when clinical staff place a patient in seclusion or restraint.

Failure to establish a comprehensive policy on seclusion and restraint places patients at risk for physical or psychological harm related to inadequate monitoring and assessments during a seclusion or restraint episode.

Findings included:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
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<th>(X3) DATE SURVEY COMPLETED</th>
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<td>013220</td>
<td>A. BUILDING:</td>
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<td>B. WNO</td>
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**NAME OF PROVIDER OR SUPPLIER**

RAINIER SPRINGS

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2805 N 129TH ST
VANCOUVER, WA 98686

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>1. Document review of the hospital's policy titled, &quot;Seclusion and Restraint,&quot; policy number 5099256, last revised 07/18, showed that a staff member will conduct continuous in-person observation/monitoring for the duration of the seclusion or restraint episode. The policy did not address the time interval and documentation requirements for the observations and interventions that must be recorded when patients are in seclusion or restraint.</td>
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<td>2. On 08/28/18 between 1:00 PM and 2:00 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) about the hospital's policy for seclusion and restraint. Staff #301 confirmed the policy did not specify how often observations or interventions must be recorded in the seclusion/restraint order/progress note. She did state that the expectation is for staff to complete observations or interventions every five minutes.</td>
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<td>L1375</td>
<td>322-210.3C PROCEDURES-ADMINISTER MEDS</td>
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<td>WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to establish an approved written policy and procedure addressing override</td>
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<tr>
<td>L1375</td>
<td>Continued From page 16 medications in the automated dispensing machine. Failure to have an approved written policy and procedure risks staff confusion and delay in medication administration. Findings included: 1. Document review of the hospital's policy, &quot;Overrides,&quot; policy number PHRM-1-107, last revised 08/14/18, showed that the hospital leadership had not approved the pharmacy policies at the time of review. 2. On 08/28/18 at 10:30 AM, Surveyor #3 interviewed the Director of Pharmacy (Staff #302) about the hospital policies and procedures for the pharmacy. Staff #302 stated that the hospital had not held a pharmacy and therapeutics meeting yet to discuss adopting and approving the Springstone corporate pharmacies policies for the hospital.</td>
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<tr>
<td>L1395</td>
<td>322-210.3G PROCEDURES-USE OF MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (g) Use of medications and drugs owned by the patient but not dispensed by the hospital pharmacy, including: (i) Specific written orders; (ii) Identification and administration of drug; (iii) Handling, storage and</td>
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<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETE DATE</td>
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<tr>
<td>L1395</td>
<td>Continued From page 17 control; (iv) Disposition; and (v) Pharmacist and physician inspection and approval prior to patient use to ensure proper identification, lack of deterioration, and consistency with current medication profile. This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to establish an approved written policy and procedure addressing the use of medications owned by the patient but not dispensed by the hospital pharmacy. Failure to have an approved written policy and procedure for patient-owned medications risks medications errors and adverse drug reactions. Findings included: 1. Document review of the hospital's policy, &quot;Medications Brought by Patient or Delivered by Courier,&quot; policy number PHRM-1-026, last revised 06/13/13, showed that the hospital leadership had not approved the pharmacy policies at the time of review. 2. On 08/28/18 at 10:30 AM, Surveyor #3 interviewed the Director of Pharmacy (Staff #302) about the hospital policies and procedures for the pharmacy. Staff #302 stated that the hospital had not yet held a pharmacy and therapeutics meeting to discuss adopting and approving the Springstone corporate pharmacies policies for the hospital.</td>
<td>L1395</td>
<td>L1400</td>
<td>322-210.3H PROCED-MEDS IN PATIENT AREAS</td>
</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>013220</td>
<td>COMPLETE</td>
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</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAINIER SPRINGS</td>
<td>2805 N 129TH ST, VANCOUVER, WA 98686</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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</thead>
<tbody>
<tr>
<td>L1400</td>
<td></td>
<td>Continued From page 18 WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (h) Maintaining drugs in patient care areas of the hospital including: (i) Hospital pharmacist or consulting pharmacist responsibility; (ii) Legible labeling with generic and/or trade name and strength as required by federal and state laws; (iii) Access only by staff authorized access under hospital policy; (iv) Storage under appropriate conditions specified by the hospital pharmacist or consulting pharmacist, including provisions for: (A) Storing medicines, poisons, and other drugs in a specifically designated, well-illuminated, secure space; (B) Separating internal and external stock drugs; and (C) Storing Schedule II drugs in a separate locked drawer, compartment, cabinet, or safe; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the hospital failed to ensure medications were available for patient use. Failure to have medications readily available for patient use risks patient safety and delayed treatment. Findings included:</td>
<td>L1400</td>
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<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<tr>
<td>L1400</td>
<td>Continued From page 19</td>
<td>L1400</td>
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</table>

1. On 08/28/18 between 8:50 and 10:30 AM, Surveyor #3 inspected the "Meadow" nursing unit and the hospital pharmacy. The observation showed there were no medications stored in the pharmacy or in the nursing unit's automated dispensing machine.

2. At the time of the inspection, Surveyor #3 interviewed the Pharmacy Director (Staff #302) about the availability of medications within the facility. Staff #302 stated that the hospital did not have any medications on-site but was expecting to receive their medications within the next one to three days.
**INITIAL COMMENTS**

This report is the result of an unannounced Fire and Life Safety survey conducted at the Rainier Springs Hospital on August 20, 2018 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health.

The new section of the 2012 Life Safety Code was used in accordance with 42 CFR 485.623.

The facility is a II-B construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way.

The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.

The surveyor was:

Nicholas Wolden  
Deputy State Fire Marshal

**NFPA 101 Corridor Doors**

Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:

013220

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: 01 - ADDITION FOR REG SET
B. WANG _______________________

(X3) DATE SURVEY COMPLETED

06/20/2018

NAME OF PROVIDER OR SUPPLIER

RAINIER SPRINGS

STREET ADDRESS, CITY, STATE, ZIP CODE

2805 N 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

S 363 Continued From page 1

Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted.

18.3.6.3, 42 CFR Parts 403, 418, 480, 482, 483, and 485

Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.

This STANDARD is not met as evidenced by:

Based on observation and staff interview on August 20, 2018 between approximately 0930 to 1330 hours the facility has failed to maintain doors without impediments to their closing and latching. This could result in a delay in getting the door to the room closed in the event of a fire.

This could result in toxic products of combustion getting into the room and into the exit corridor which would endanger the patients, staff and/or visitors within the smoke compartment.

The findings include, but are not limited to:

Doors to rooms 308 and 520 did not have hardware to properly close and latch.

The above was discussed and acknowledged by the facility staff.

S 918 NFPA 101 Electrical Systems Essential Electric Syste

S 918
<table>
<thead>
<tr>
<th>ID TAG</th>
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<tbody>
<tr>
<td>S 918</td>
<td>Continued From page 2</td>
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</table>

**Electrical Systems - Essential Electric System**

A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)

This STANDARD is not met as evidenced by:

Based on observation and staff interview on August 20, 2018 between approximately 0930 to 1130 hours the facility has failed to maintain and test the emergency generator in accordance with NFPA 110. This could result in a failure of the emergency power system which would leave the facility without egress and task lighting in the event of a power failure which would endanger the patients, staff, and/or visitors within the facility.

The findings include, but are not limited to:

The facility did not have the proper amount of generator fuel per NFPA 110 2010 and associated WACs and RCWs.

The above was discussed and acknowledged by the facility staff.

**S 923** NFPA 101 Gas Equipment Cylinder and Container Storag

Gas Equipment - Cylinder and Container
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<tr>
<th>ID</th>
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</thead>
</table>
| S 923 | **Storage**<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>&gt;300 but &lt;3,000 cubic feet<br>Storage locations are outdoors in an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."
<p>| S 923 | <strong>Storage</strong> is planned so cylinders are used in order of which they are needed. |</p>
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETE DATE</th>
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</thead>
<tbody>
<tr>
<td>S 923</td>
<td>Continued From page 4 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</td>
<td>S 923</td>
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</tr>
<tr>
<td>Deficiency Number and Rule Reference</td>
<td>Plan of Correction</td>
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| L210  WAC 246-322-030 Reference: RCW 43.43.834 | Plan to correct the deficiency:  
Implement a process that all employee who are hired have a WATCH background check completed. Update Policy to reflect this practice.  
Procedure for implementing plan:  
HR Director will run Watch reports alongside standard background checks for all new employees.  
Monitoring of procedure:  
HR Director will audit charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy in personnel files.  
Checklist addendum that is used internally to ensure this is being run.  
Title of person responsible for plan of correction:  
Director of Human Resources  
How the deficiency was corrected: HR Director completed WATCH reports on all employees who were hired during initial DOH audit.  
Completion date:  
For current employees 09/05 completed. For future employees, at the same time as background check before hire/start date  
How the plan will prevent possible recurrence of deficiency:  
Checklist addendum that is used internally to ensure this is being run upon hire and annual there after  
Plan to correct the deficiency:  
All new employees are asked for their consent prior to completing background check. Employees are asked in application process if they have committed a crime. Background check run by Rainier Springs covers all crimes referenced in RCW  
Procedure for implementing plan:  
Prior to hire employees are receiving both a background check and WATCH background check.  
Monitoring of procedure: |
Director of Human Resources will review all background checks
Title of person responsible for plan of correction:
**Director of Human Resources**
How the deficiency was corrected:
**This plan is the practice of Rainier Springs**
Completion date:
**All employees currently hired have consented to a background check and Rainier Springs has completed the background check**
How the plan will prevent possible recurrence of deficiency:
**Rainier Springs Director of Human Resources will ensure all employees providing patient care and employed with the hospital meets the requirements of this WAC through the process of background checks and WATCH.**

<table>
<thead>
<tr>
<th>L 305</th>
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<tbody>
<tr>
<td>WAC 246-322-035 (1)(a)</td>
<td><strong>Policies-Admit Criteria</strong></td>
</tr>
</tbody>
</table>

Plan to correct the deficiency:
Update the following Policies to reflect WA involuntary detention process:
1) Discharge Against Medical Advice Policy
2) Involuntary Treatment Act Process and Evaluation Timelines Policy
Procedure for implementing plan:
**Regional Vice President of Clinical services will update policy**
Monitoring of procedure:
**Director of Nursing, Chief of Medicine, Director of Admissions, and Director of Clinical Services will monitor this practice.**
Title of person responsible for plan of correction:
**Regional VP of Clinical Services**
How the deficiency was corrected:
**Policies were updated to reflect state specific voluntary detention process**
| L370 | Plan to correct the deficiency:  
| WAC 246-322-035(1)(n)  
POLICIES-PT WORK  
WAC 246-322-180  
Policy for addressing patients working at the facility as part of their treatment plan - reference to "Patient Work" policy provided, but not approved | Approve Patient Work Policy  
Procedure for implementing plan:  
Policy will ensure practice  
Monitoring of procedure:  
All employees of Rainier Springs will adhere and monitor this policy  
Title of person responsible for plan of correction:  
Program Manager  
How the deficiency was corrected:  
Policy was approved by Springtone  
Completion date:  
9-12-2018  
How the plan will prevent possible recurrence of deficiency:  
This policy and hospital practice prohibits patients from working at the facility. |
| L405 | Plan to correct the deficiency:  
WAC 246-322-035 (1)(u)  
WAC 246-322-200  
70.05 RCW  
Title 42 CFR Chapter 1 part 1 10/1/89  
Policy for addressing time interval required for completion of the comprehensive treatment plan | Update the following Policies to address time interval required of the completion of the comprehensive treatment plan. Policies updated:  
1) Treatment Planning-Philosophy and Purpose  
2) Admission Process Inpatient  
Procedure for implementing plan:  
Regional VP of Clinical Services will update the policy  
Monitoring of procedure:  
Director of Nursing, Chief of Medicine, Director of Admissions, and Director of Clinical Services will monitor this practice.  
Title of person responsible for plan of |
The Comprehensive Psychiatric Evaluation ("CPE") must be completed and dictated within 24 hours of admission. The transcribed report will be filed in the record within 48 hours of admission. If the CPE is handwritten, it must be completed and filed in the record within 24 hours of admission.

Monitoring of procedure:
Nightly CPEs audits by nursing staff, director of nursing and reported to quality director.

Title of person responsible for plan of correction:
CEO of Springstone

How the deficiency was corrected:
Policy was updated and approved

Completion date:
9-11-2018

How the plan will prevent possible recurrence of deficiency:

Update and approve Admission Process Policy
Procedure for implementing plan:

L485
WAC 246-040(8)(g)

Hospital's medical staff rules and regulations should include the time interval for comprehensive psychiatric evaluation.

It is 72-hour time interval for completion following the patient's admission (Policy: Medical Staff Rules and Regulations)
State of Washington Department of Health  
Initial Licensing survey completed on August 28th, 2018 by Lisa Mahoney

<table>
<thead>
<tr>
<th>Procedure and Policy ensures that all patients will received their comprehensive psychiatric evaluation in a timely manner and the nightly chart audits will ensure that policy is being followed.</th>
</tr>
</thead>
</table>
| L505  
WAC 246-322-050(1)(a)  
Reference WAC 246-841-400 and WAC 246-841-0400  
PCA - JD should include requirements for obtaining of an affiliated agency counselor credential |
| Plan to correct the deficiency:  
Rainer Springs will ensure all PCAs providing patient care under the Behavioral Health Agency License will be credentialed by Department of Health as an Agency Affiliated.  
Procedure for implementing plan:  
Once Rainier Springs gets licensed all PCAs will apply for a DOH credential. All hires post license will apply for their credential 7 days upon hire.  
Monitoring of procedure:  
HR director will monitor all pending Agency Affiliated counselor application in DOH to ensure employees are working with in the 60 day window.  
HR Director will audit charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy in personnel files. Added to checklist to ensure HR Director receives all copies of valid credential. HR Director will review personnel files to check for current license in file.  
Title of person responsible for plan of correction:  
Director of Human Resources  
How the deficiency was corrected:  
Educated senior leadership of WA requirement and will initiate process once licensee arrives.  
Completion date:  
Unable to complete at this time due to no current license. Once license is received will have all PCAs apply for credential.  
How the plan will prevent possible recurrence of deficiency:  
Rainier Springs will require all PCAS to have an active credential with DOH, therefore this will ensure all employees are practicing with scope of practice under a Behavioral Health Agency. |
<table>
<thead>
<tr>
<th>NOTE: Job Description for PCAs has been updated to reflect job duties under the scope of Agency Affiliate only (see attached). Completed on 9-13-2018. Personal responsible for updated Job Description VP of Human Resources. By updating the Job Description it will ensure that all PCAs practice with in their scope of their credential provided by DOH.</th>
</tr>
</thead>
</table>
| L 530  
WAC 246-322-050  
Must verify work references prior to hiring staff |
| Plan to correct the deficiency:  
HR director will use Reference Check Form for all potential hires. The reference comments is documented on that form and will be placed in the personnel file.  
Procedure for implementing plan:  
HR will use Reference Check form when checking all references for potential and will be in the personnel file.  
Monitoring of procedure:  
Springstone Internal check list monitors that all references are loaded in the personnel file. Human Resources uses this check list will all new employees.  
HR Director will audit charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy in personnel files.  
Title of person responsible for plan of correction:  
Director of Human Resources  
How the deficiency was corrected:  
Director of Human Resources reviewed all current employees and used internal check list to confirm if references were located in the personnel file.  
Completion date:  
9-21-2018  
How the plan will prevent possible recurrence of deficiency: |
<table>
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<tr>
<th>L615</th>
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<tbody>
<tr>
<td>WAC 246-322-050</td>
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<tr>
<td><strong>TB tests - upon employment or starting service and each year thereafter</strong></td>
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</tbody>
</table>

By using the internal checklist upon hire, it will assure that all references are in the personnel file.

Plan to correct the deficiency:

All new employees are required to complete the Employee Health Questionnaire which asks employee date of last TB Screening and date of last TB test. New employees are provided TB testing on site during new orientation if not provided with documentation with the past 6 months.

Procedure for implementing plan:

TB test were offered during new orientation program.

Monitoring of procedure:

Infection control nurse will track employee health data base that includes: employee name, hire date, health questionnaire, UDS, initial TB plus annual TB, annual flu shot and Hep consent.

All employee TB test results will be stored in Medical Records for confidentiality and managed by Infection Control Nurse.

Infection Control Nurse will audit Employee Health Files charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy.

Title of person responsible for plan of correction:

Director of Human Resources, Director of Nursing, Supervisors, Infection Control Nurse,

How the deficiency was corrected:

Employee personal health files were created and Ultra Pro tracking was established.

Completion date:

9-14-18

How the plan will prevent possible recurrence of deficiency:

Providing employees onsite testing and the Infection Nurse monitoring Employee Health Files will ensure that all employees are current on their TB testing.
<table>
<thead>
<tr>
<th>L985</th>
<th>Plan to correct the deficiency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>WAC 246-322-150</td>
<td>Purchase lights for medical exam rooms and educate EOC about the requirements of exam lights in medical exam rooms.</td>
</tr>
<tr>
<td>Exam Room Light</td>
<td>Response: On 09/06/2018, three Welch Allyn GS 300 General Exam Lights were delivered and installed in three exam rooms, rooms # 426, 522 and 626.</td>
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<tr>
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<td>Responsible Individual: EOC Director, Rainier Springs Biomedical Engineer (Calem Medical Inc.)</td>
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<tr>
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<td>Date of Correction: 9/6/2018</td>
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<td></td>
<td>Monitoring Procedure: Exam lights have been added to the hospital medical equipment inventory and will be maintained as part of mandatory equipment management program.</td>
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<tr>
<td></td>
<td>How the plan will prevent possible recurrence of deficiency: With the purchase of the exam lights it will ensure that Rainier Springs will comply to this WAC</td>
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<thead>
<tr>
<th>L1125</th>
<th>Plan to correct the deficiency:</th>
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<tbody>
<tr>
<td>WAC 246-322-170</td>
<td>M.T is currently hired at Rainier Springs to provide Rec Therapy and her start date is October 8th, 2018. In addition, E.M is licensed as CTRS and her start was 9-5-2018. Heather Steiner is interim Rec Therapist until M.T and E.M have completed their onboarding. M.T will be the identified Rec Therapist supervisor in addition to Carey Sebera (LASW, Director of Clinical Services).</td>
</tr>
<tr>
<td>Need a recreational or occupational therapist to coordinate and supervise rec therapy services</td>
<td>Procedure for implementing plan: New employees will continue with onboarding and competences.</td>
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<td>Monitoring of procedure: Director of Clinical Services will ensure that Rec Therapy is being supervised.</td>
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<tr>
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<td>Title of person responsible for plan of</td>
</tr>
<tr>
<td>L1145</td>
<td>WAC 246-322-180</td>
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<tr>
<td>Restraint/Seclusion Policy - address the recording of observations and interventions in the clinical record when clinical staff place a patient in seclusion or restraint - policy should specify time interval and documentation requirements for the observations and interventions that must be recorded when patients are in seclusion or restraint - policy must include how often observations or interventions must be recorded in the seclusion/restraint order/progress note.</td>
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| Plan to correct the deficiency: |
| Update policy to reflect current requirements outlined in WAC 246-322-180. Policy updated: |

1) Seclusion and Restraint

Procedure for implementing plan:
Regional VP of Clinical Services will update the policy
Monitoring of procedure:
Director of Nursing, Chief of Medicine, Medical Doctors, Director of Clinical Services, Nursing Manager.
Title of person responsible for plan of correction:
Regional VP of Clinical Services

How the deficiency was corrected:
Policy was updated appropriately
Seclusion and Restraint
Completion date:
9-11-2013

How the plan will prevent possible recurrence of deficiency:
By updating the Restraint/Seclusion policy it will ensure that clinical staff will document per the requirements when a patient is placed in restraint/seclusion. | Correction: Director of Clinical Services and Director of Human Resources

How the deficiency was corrected:
Since the initial audit two Rec Therapist have been hired (see above) and one identified as the Rec Supervisor.
Completion date:
Interim Rec Therapist Heather Steiner will fly out to Rainier Springs once the unit opens.
How the plan will prevent possible recurrence of deficiency:
By hiring two Rec Therapist and identifying one as the supervisor, it will ensure that all rec therapist are receiving supervision. |
| L1375 | Plan to correct the deficiency:  
Policy and procedure addressing override medications in the automated dispensing machine. - issue seems to be that hospital leadership didn't approve the pharmacy policies at the time of review - hospital has not had a pharmacy and therapeutics meeting yet to discuss adopting and approving the Springstone corporate pharmacies policies for the hospital.

Plan to correct the deficiency:  
Schedule Pharmacy and therapeutic committee meeting to approve Springstone corporate pharmacies policies for the hospital.

Procedure for implementing plan:
Schedule Pharmacy and therapeutic committee meeting
Monitoring of procedure:
Pharmacy Policies reviewed and approved
Title of person responsible for plan of correction:
Medical Director,
How the deficiency was corrected:
Meeting was scheduled and minutes were documented
Completion date:
9-5-2018
How the plan will prevent possible recurrence of deficiency:
The approval of the policies ensures that Rainier Springs will adopt to all Springstone corporate pharmacies policies for the hospital. |

| L1395 | Plan to correct the deficiency:  
Procedure-Use of Meds  
WAC 246-322-210 3(G)  

Plan to correct the deficiency:  
Approve Medications brought by Patient or Deliver by Courier policy

Procedure for implementing plan:
Policies will be reviewed in Med Executive Meeting and voted on during that meeting

Monitoring of procedure:
Minutes will be taken to communicate policy approval and policy will be approved and placed in Policy Stat

Title of person responsible for plan of correction:
Medical Director Dr. Simas

How the deficiency was corrected:
Med Executive Meeting was scheduled for 9-13-2018

Completion date:
9-13-2018

How the plan will prevent possible recurrence of deficiency: |
<table>
<thead>
<tr>
<th>Deficiency Number and Rule Reference</th>
<th>Plan of Correction</th>
</tr>
</thead>
</table>
| L210 WAC 246-322-030 Reference: RCW 43.43.834 | **DEPARTMENT OF HEALTH**

**Plan to correct deficiency:**

1. **Human Resources** will create a document that asks all applicants to disclose to Rainier Springs if they have had any findings made against them as defined in RCW 43.43.830.

2. **Human Resources** will create a document that all employees can sign attesting that they have been provided a copy of their Watch report.

3. **Human Resources** will update the background check release form that will inform all applicants a Washington State Patrol inquiry will be made and they will be notified within 10 days of the report.

**Procedure for implementing plan:**

1. **HR** will have all applicants' complete form titled Criminal History Attestation after the applicant has been offered the position. **HR** will review the document and confirm the applicant does not have any findings made against them as defined in RCW 43.43.830.

2. **HR** will have all employees sign form titled WATCH Report Attestation at pre-employment meeting.

3. All applicants will receive pre-employment documents that include the form titled Background Check Release Electronic WA.

**Monitoring of procedure:**

HR Director will audit charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy in personnel files.

**Title of person responsible for plan of correction:**

HR Director of Rainier Springs and Senior Director of Human Resources with Springstone

**How the deficiency was corrected:**

Additional paperwork to capture the required information was created and implemented in the new hire process.

**Completion date:**

9-18-2018

**How the plan will prevent possible recurrence of deficiency:**

Updating the application will ensure that Rainier Springs is collecting criminal background information on all applicants that will be serving children or vulnerable persons.

By having employees sign the WATCH Attestation and given a copy of their WATCH it ensures that Rainier Springs is notifying the applicant of the WATCH report.
<table>
<thead>
<tr>
<th>Deficiency Number and Rule Reference</th>
<th>Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>L530 Working references</td>
<td>Plan to correct the deficiency: HR Director will use Reference Check Form for all potential hires. The reference comments is documented on that form and will be placed in the personnel file. Procedure for implementing plan: HR will use Reference Check form when checking all references for potential and will be in the personnel file. Monitoring of procedure: Springstone Internal check list monitors that all references are loaded in the personnel file. Human Resources uses this check list will all new employees. HR Director will audit charts for the next 90 days and submit audit tools for Quality Committee for the next 90 days to ensure 100% accuracy in personnel files. Title of person responsible for plan of correction: Director of Human Resources How the deficiency was corrected: Director of Human resources reviewed all current employees and used internal check list to confirm if references were located in the personnel file. Completion date: 9-21-2018 How the plan will prevent possible recurrence of deficiency: By using the Internal checklist upon hire, it will assure that all references are in the personnel file.</td>
</tr>
<tr>
<td>L1125 Recreational Therapist</td>
<td>Plan to correct the deficiency: Marissa Totti (Bachelor in Rec Therapy) is currently hired at Rainier Springs to provide Rec Therapy and her start date is October 8th, 2018 pending her CTRS. In addition, Emily Myers ID #62281 is licensed as CTRS and her start date was 9-5-2018. Heather Steiner, CTRS ID#60998 and Kendall Quillin, CTRS ID# 65602 is interim Rec Therapist until Marissa Totti is certified and on-boarded. Marisa Totti will be the</td>
</tr>
<tr>
<td>Deficiency Number and Rule Reference</td>
<td>Plan of Correction</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>L0150 Admission Policy</td>
<td></td>
</tr>
<tr>
<td>Plan to correct the deficiency:</td>
<td></td>
</tr>
<tr>
<td>Updated Medical Staff Rules and Regulations policy</td>
<td>Plan of Correction</td>
</tr>
<tr>
<td>August 29th, 2018 Meadows pyx was stocked (see attached pictures)</td>
<td>Plan of Correction</td>
</tr>
</tbody>
</table>

**Deficiency 0150:** Admission Policy

**Deficiency 0305:** Admission Criteria Policy

**Plan of Correction:**
- By hiring two Rec Therapist and identifying one as the supervisor, it will ensure that all Rec Therapists are receiving supervision.
- Since the initial audit, two Rec Therapists have been hired (see above) and one identified as the Rec Supervisor.

**Plan of Correction:**
- How the plan will prevent possible recurrence of the deficiency by hiring two Rec Therapists and identifying one as the supervisor.
<table>
<thead>
<tr>
<th>L1400 322-210.3H</th>
<th>The plan will ensure that patients and staff have clear direction on how to address medication owned by patient and not dispensed by the hospital pharmacy.</th>
</tr>
</thead>
</table>
| Procedure-meds in patient areas | Plan to correct the deficiency:  
Medication will be loaded in the Pyxis machine  
Procedure for implementing plan:  
Once medications are delivered load in Pyxis machine  
Monitoring of procedure:  
Pharmacist in charge will ensure that medications are loaded in the Pyxis  
Title of person responsible for plan of correction:  
**Pharmacist in charge**  
How the deficiency was corrected:  
**Medications were loaded into the Pyxis**  
Completion date:  
**How the plan will prevent possible recurrence of deficiency:**  
By having the medications on site, it will ensure that all patients receive medications in a timely manner |

| S363 Corridor Doors 42 CFR 485.623 | Plan to correct the deficiency:  
The plan is to purchase the correct hardware for room 308 and 520  
Procedure for implementing plan:  
General contractor Andersen will replace hardware.  
Monitoring of procedure:  
**EOC**  
Title of person responsible for plan of correction:  
**EOC**  
How the deficiency was corrected:  
**Hardware was purchased and installed**  
Completion date:  
8/20/2018  
**How the plan will prevent possible recurrence of deficiency:** |
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| S918 | Electrical Systems  
Essential Electric System  
NFPA 99  
Facility must maintain and test the emergency generator in accordance with NFPA 110. Facility did not have the proper amount of generator fuel per NFPA 110 2010 |
| S923 | Gas Equipment Cylinder and Container Storage  
NFPA 99  
Proper storage of gas cylinders – must secure CO2 cylinders |

| Plan to correct the deficiency: |
| EOC will ensure there proper amount of fuel to maintain the emergency generator.  
Procedure for implementing plan:  
Enforcement safety tours and required monthly generator inspections.  
Monitoring of procedure:  
Generator is tested monthly and fuel levels are checked periodically never allowed to go below quarter of a tank  
Title of person responsible for plan of correction:  
EOC Director, Rainier Springs  
Verified the tank was full  
Completion date:  
8/21/2018  
How the plan will prevent possible recurrence of deficiency:  
The plan will ensure that in a time of emergency the emergency generator will be able to sustain the building needs. |

| Plan to correct the deficiency: |
| EOC will relocate CO2 and secure with chains.  
Procedure for implementing plan:  
Tanks were secured and stored in a rated enclosure general store room.  
Monitoring of procedure:  
Maintenance Tech will review 1x a week CO2 cylinders to ensure proper storage.  
Title of person responsible for plan of correction: |
<table>
<thead>
<tr>
<th>EOC Director, Rainier Springs Maintenance Tech</th>
</tr>
</thead>
<tbody>
<tr>
<td>How the deficiency was corrected:</td>
</tr>
<tr>
<td>Tanks were changed up and secure</td>
</tr>
<tr>
<td>Completion date:</td>
</tr>
<tr>
<td>8/21/2018</td>
</tr>
<tr>
<td>How the plan will prevent possible recurrence of deficiency:</td>
</tr>
<tr>
<td>The new location and procedure of secured tanks will ensure the proper storage of gas cylinders.</td>
</tr>
<tr>
<td>Tag Number</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>L210</td>
</tr>
<tr>
<td>L 305</td>
</tr>
<tr>
<td>L370</td>
</tr>
<tr>
<td>L405</td>
</tr>
</tbody>
</table>
| WAC 246-322-035 (1)(u) | interval required of the completion of the comprehensive treatment plan. Policies updated:  
1) Treatment Planning-Philosophy and Purpose  
2) Admission Process Inpatient |
|-------------------------|-----------------------------------------------------------------------------------|
| WAC 246-322-200 70.05 RCW | L485  
WAC 246-040(8)(g)  
Education was provided to all doctor(s) that The Comprehensive Psychiatric Evaluation ("CPE") must be completed and dictated within 24 hours of admission. The transcribed report will be filed in the record within 48 hours of admission. If the CPE is handwritten, it must be completed and filed in the record within 24 hours of admission. In addition, the policy was updated to reflect changes.  
9-11-2018 Policy was updated and approved |
| Chart audits reflect CPE has been dictated within 24 hours and is in the chart within 48 hours.  
FINDINGS: It was discovered since opening that CPEs were being printed to medical records instead of the unit. Immediate action was taken and the first change to ensure this WAC was being met was to have all dictations printed to the unit. The second finding included that doctors were not electronically signing their CPE, therefore this process has been resolved. The last action resulted in discovering the dictation contract processed dictations within 24 hours. This process is currently being worked on and the turnaround time will be 4 hours from dictation. Charts audited in October: 100% (15 out of 15) CPEs were dictated in |
<table>
<thead>
<tr>
<th>LS05</th>
<th>Rainier Springs had all current PCAs apply for their agency affiliate once notification of licensing was approved. All on boared PCAs applied once hired.</th>
<th>Audit checks completed by HR confirmed that current employees applied for their Agency Affiliate. In addition, all new employees are informed of this requirement therefore it ensures that all PCAs are also Agency Affiliates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>LS05 (1)</td>
<td>Reference WAC 246-841-0400</td>
<td></td>
</tr>
<tr>
<td>L530</td>
<td>Springstone Internal check list monitors that all references are loaded in the personnel file. Human Resources uses this check list will all new employees.</td>
<td>Audit checks completed by HR determined that reference checks were being completed on all employees. FINDINGS: 50 charts audited and 100% had 2 references</td>
</tr>
<tr>
<td>L530</td>
<td>9-21-2018</td>
<td></td>
</tr>
<tr>
<td>L615</td>
<td>Infection control nurse tracked employee health data base that includes: employee name, hire date, health questionnaire, UDS, initial TB plus annual TB, annual flu shot and Hep consent. In addition, she created a spread sheet to document and track all employee.</td>
<td>Audits report that employees are up to date on their TB testing. FINDINGS: 95% of employee audited for the month of October were in compliance with TB testing (86 out of 90). Data is collected on all employees monthly and tracked and reported to Director of Quality by the 15th of every month. Data is stored in a confidential room that the infection control nurse oversees. She has created an excel spread sheet that tracks outstanding TB tests. In</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Date</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>L985</td>
<td>Purchased lights for medical exam rooms and educate EOC about the requirements of exam lights in medical exam rooms.</td>
<td>9-6-2018</td>
</tr>
<tr>
<td>WAC 246-322-150 Exam Room Light</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L1125</td>
<td>E.M applied for her Washington Recreational Therapy License</td>
<td>RE60902651 Issued on 10/25/2018 ACTIVE</td>
</tr>
<tr>
<td>WAC 246-322-170</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WAC 246-322-180</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L1375</td>
<td>Meeting was scheduled and minutes were documented</td>
<td>9-5-2018</td>
</tr>
<tr>
<td>Procedures-Administer Meds</td>
<td>WAC 246-322-210 3.C</td>
<td></td>
</tr>
<tr>
<td>L1395</td>
<td>Med Executive Meeting occurred on 9-13-2018 and Polices were reviewed in Med Executive Meeting and voted on during that meeting</td>
<td>9-13-2018</td>
</tr>
<tr>
<td>Procedure-Use of Meds</td>
<td>WAC 246-322-210 3(G)</td>
<td></td>
</tr>
<tr>
<td>L1400</td>
<td>Medication was loaded in the Pyxis</td>
<td>9-29-2018</td>
</tr>
<tr>
<td>322-210.3H Procedure-meds in patient areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S363</td>
<td>Hardware was replaced</td>
<td>8-20-2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corridor Doors</td>
<td>S918 Environmental safety tours and required monthly generator inspections.</td>
<td>8-21-2018 Testing the generator monthly has ensured that emergency generator is able to stain building needs. Audits confirm this is occurring and the generator level is ready to support the building in an event of an emergency.</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>42 CFR 485.623</td>
<td>S918 Electrical Systems Essential Electric System NFPA 99 Facility must maintain and test the emergency generator in accordance with NFPA 110. Facility did not have the proper amount of generator fuel per NFPA 110 2010.</td>
<td>8-21-2018 Tanks were secured and stored in a rated enclosed general store room.</td>
</tr>
<tr>
<td></td>
<td>S923 Gas Equipment Cylinder and Container Storage NFPA 99 Proper storage of gas cylinders - must secure CO2 cylinders</td>
<td>No monitoring required.</td>
</tr>
</tbody>
</table>

**DATA COLLECTED for the Month of October**

<table>
<thead>
<tr>
<th>Compliance with TB testing of all employees</th>
<th>95%</th>
<th>all</th>
<th>86</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>0.00%</td>
<td>0.00%</td>
<td>95.00%</td>
</tr>
</tbody>
</table>
September 28, 2018

Gary Petersen, MBA, CEO
Rainier Springs Hospital
2805 NE 129th St.
Vancouver, WA 98686

Dear Mr. Petersen:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau completed a state Private Psychiatric and Alcoholism hospital licensing survey at Rainier Springs Hospital on August 28, 2018. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on September 28, 2018.

A Progress Report is due on or before November 26, 2018 when all deficiencies have been corrected and monitoring for 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 mail this progress report to me at the following address:

Lisa Mahoney, MPH, PHA
Department of Health, Investigations and Inspections Office
P.O. Box 47874
Olympia, WA  98504

Please contact me if you have any questions. I may be reached at 360-236-2972. I am also available by email at Lisa.Mahoney@doh.wa.gov

Sincerely,

Lisa Mahoney, MPH, PHA
Survey Team Leader