	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDICAN	OF CORRECTION	IDENTIFICATION NOINDER.	A. BUILDING:		COMPLETED
		013319	B. WNG		C 03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	
		605 WO	ODLAND SQUAI	RE LOOP SE	
SOUTHS	OUND BEHAVIORAL HO	SPITAL LACEY,	WA 98503		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE
L 000	INITIAL COMMENTS	3	L 000		
	(DOH) in accordance Administrative Code ( Private Psychiatric ar conducted this compl	e Department of Health with Washington (WAC), Chapter 246-322 and Alcoholism Hospitals, aint investigation.  3, 03/01/23, & 03/09/23		1. A written PLAN OF CORRECTION required for each deficiency listed on Statement of Deficiencies.  2. EACH plan of correction statement must include the following: The regulanumber 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 monite continued compliance; and	the tation
	There were violations complaint.	found pertinent to this		WHEN the correction will be completed.  3. Your PLANS OF CORRECTION makes the returned within 10 days from the dayou receive the Statement of Deficier.  Your Plans of Correction must be postmarked by 04/03/23.  4. Email the ORIGINAL REPORT with the required signatures.	uust late ncies.
L 335	322-035.1G POLICIE	S-EMERGENCY CARE	L 335		
State Form 25	WAC 246-322-035 Pc Procedures. (1) The li develop and impleme written policies and pr consistent with this ch services provided: (g)	icensee shall nt the following rocedures napter and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A, BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		
		013319	B. WNG		C 03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	F. ZIP CODE	•
		605 WOO	DDLAND SQUARE		
SOUTH S	OUND BEHAVIORAL HO	SPITAL	WA 98503		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
L 335	Continued From page	÷1	L 335		
	medical care, includir orders; (ii) Staff action absence of a physicia and accessing emergequipment; This Washington Admas evidenced by: Based on observation review, the hospital feand procedures, for the emergencies and transcompleted and docum when medical emerge events (Item #1), com Memorandums of Trapatients (Patients #1, #2), and facilitated pr Medical Services for reviewed (Patients #8, #12) (Item #3).  Failure to implement the management of management	ng: (i) Physician ns in the an; (iii) Storing ency supplies and ninistrative Code is not met an, interview, and document alled to implement policies the management of medical nsfers, to ensure staff mented incident reports encies occurred for 36 of 48 anpleted and documented unsfer for 5 of 14 transferred #2, #3, #4, and #5) (Item ompt access to Emergency 7 of 7 emergency responses 5, #7, #8, #9, #10, #11, and policies and procedures for medical emergencies and t harm from delayed or			
	Document review of t	the hospital's policy titled			

State Form 2567

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JD CODE  SOW WOODLAND SAUAREL LOOP SE  LACEY, WA 98503  (A) D  SEMENT STATEMENT OF DETICENCIES  TAG  SEMENTATION  SEMENTATION OF SEMENTATION OF DETICENCIES  TAG  COntinued From page 2  "Medical Emergencies," no policy ID, effective O4/2019, last reviewed 01/2021, showed that in the event of a medical emergency, defined as an unexpected illness or injury, an incident report will be completed documenting details of any event.  Document review of the hospital's policy titled "Emergency Medical Streening," policy #PC 034, effective 04/2019, last reviewed 01/2022 showed the following: a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings.  b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.  c. Staff will complete an incident report and routle it to the P1 Director.  2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacey Fire Department 911 (emergency) responses to the hospital between 12/02/22 and 03/02/23 and a hospital incident report log of all lacet reports between 12/02/22 and 03/02/23. The review showed the following: a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.  b. Of the 48 emergency responses to the hospital, 36 were missing corresponding hospital incident reports.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
SOUTH SOUND BEHAVIORAL HOSPITAL   SUMMARY STATEMENT OF DEFICIENCIES   CACH, WA 98503   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   CACH, WA 98503   PREFIX   TAG   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG			013319	B. WNG		03	
CASID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH CORRECTION MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-ARCH CORRECTIVE ACTION SHOULD BE (CROSS-ARCH CORRECTION SHOULD BE (CROSS	NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	E, ZIP CODE		
TAG  Continued From page 2  "Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that in the event of a medical emergency, defined as an unexpected illness or injury, an incident report will be completed documenting details of any event.  Document review of the hospital's policy titled "Emergency Medical Screening," policy #PC 034, effective 04/2019, last reviewed 07/2020 showed the following:  a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings.  b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.  c. Staff will complete an incident report and route it to the PI Director.  2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacey Fire Department 911 (emergency) responses to the hospital between 12/02/22 and 03/02/23 and a hospital incident report log of all incident reports between 12/01/22 and 03/08/23. The review showed the following:  a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.  b. Of the 48 emergency responses to the hospital, 36 were missing corresponding hospital	SOUTH SO	OUND BEHAVIORAL HO	SPITAL		LOOP SE		
"Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that in the event of a medical emergency, defined as an unexpected illness or injury, an incident report will be completed documenting details of any event.  Document review of the hospital's policy titled "Emergency Medical Screening," policy #PC 034, effective 04/2019, last reviewed 07/2020 showed the following:  a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings.  b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.  c. Staff will complete an incident report and route it to the PI Director.  2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacey Fire Department 911 (emergency) responses to the hospital between 12/0/222 and 03/02/23 and a hospital incident report tog of all lincident reports between 12/01/22 and 03/08/23. The review showed the following:  a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
c. On 02/28/23 at 2:30 PM, Investigators #1 and	L 335	"Medical Emergencie 04/2019, last reviewe the event of a medical unexpected illness or be completed docume."  Document review of the "Emergency Medical effective 04/2019, last the following:  a. When screening a Nursing Supervisor who explain the situation bearing. If directed, the recession of the situation of	s," no policy ID, effective d 01/2021, showed that in I emergency, defined as an injury, an incident report will enting details of any event.  The hospital's policy titled Screening," policy #PC 034, threviewed 07/2020 showed person that is not stable, the illicall the on-call physician in and findings.  The person to the epartment for assessment an incident report and route tigators #1 and #2 reviewed the person to the hospital between 3 and a hospital incident introports between 12/01/22 view showed the following:  The person to the following:  The person to the hospital between 3 and a hospital incident introports between 12/01/22 view showed the following:  The person to the hospital between 3.  The person to the hospital between 3.  The person to the hospital between 3.	L 335			

State Form 2567

PRINTED: 03/27/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING 013319 03/09/2023 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 PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 335 L 335 Continued From page 3 (Staff #1101). Staff #1101 verified that current policy was to enter an incident report if 911 is called. Item #2 - Memorandums of Transfer 1. Document review of the hospital's policy titled "Medical Emergencies," no policy ID, effective 04/2019, last reviewed 01/2021, showed that once a medical emergency has been addressed, a Memorandum of Transfer will be prepared and forwarded at the first available opportunity. Document review of the hospital's policy titled "Memorandum of Transfer," policy ID RT-017, effective date 05/2019, last reviewed 01/2022, showed the following:

reviewed the Memorandum of Transfer (MOT) file State Form 2567 STATE FORM

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

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

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

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

and city of hospital to which patient was

facilities.

transported.

hospitals.

Patient #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O		1 ` '	O) DATE SURVEY COMPLETED	
			A. BUILDING:				
		013319	B. WING		<b>I</b>	C 03/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
SOUTH S	OUND BEHAVIORAL HO	)SPITAL	ODLAND SQUARE	LOOP SE			
244.15	CI INAMANDV CI	TATEMENT OF DEFICIENCIES	WA 98503		DE CODRECTION	1 41/51	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
L 335	Continued From pag	e 4	L 335				
	for the month of 02/2 following:	3. The review showed the					
	with an infected wou	ent #1 presented to intake nd to the right forearm. ported to another facility by PM and an MOT was					
	b. Review of the MO facility was documen	T showed that no accepting ted on the form.					
	c. Staff #1104 confirm of the missing docum	ned the investigators finding nentation.					
	Patient #2						
	#2, Staff #1104 and S	00 PM, Investigators #1 and Staff #1105 reviewed the th of 02/23. The review :					
	after a suicide attemp voluntary admission.	ent #2 presented to intake of and refused to be a Patient #2 was transported ambulance at 3;18 PM and I in the file.					
		r showed that no physician was documented on the					
	c. Staff #1104 confirm of the missing docum	ned the investigators finding entation.				The state of the s	
	Patient #3						
	#2, Staff #1104 and S	0 PM, Investigators #1 and Staff #1105 reviewed the h of 02/23. The review					

State Form 2567

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	
		013319	B. WING		1	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOUTH S	OUND BEHAVIORAL HO	SPITAL 605 WOOD LACEY, W	LAND SQUAR	E LOOP SE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	1D	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETE DATE
L 335	Continued From page	÷5	L 335			
	showed the following	;				
	requesting alcohol de to have an elevated b rate. Patient #3 was t	nt #3 presented to intake stoxification and was found blood pressure and heart ransported to another facility and an MOT was retained in				
	c. Staff #1104 confirm of the missing docum	ned the investigators findings entation.				
	Patient #4					
	#2, Staff #1104 and S	0 PM, Investigators #1 and Staff #1105 reviewed the h of 02/23. The review :				
	requested admission found to be depended bathroom and showe	ent #4 presented to intake for suicidal ideation and was nt on a caregiver for ring needs. Patient #4 was nown facility at an unknown				
	b. The investigators with MOT for Patient #4.	vere unable to locate an				
	C. Staff #1104 confirm of the missing MOT.	ned the investigators finding				
	Patient #5					
	6. On 02/28/23 at 3:0	0 PM, Investigators #1 and				

State Form 2567

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013319	B. WING		C 03/09/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SOUTHS	OUND BEHAVIORAL HOS	SPITAL 605 WOOI LACEY, W	DLAND SQUAF A 98503	RE LOOP SE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	ſΕ
L 335	non-verbal admitted p	cal record of Patient #5, a atient with major depressive ideation. The review showed	L 335			
	unwitnessed fall and 9	O AM, Patient #5 had an 911 was called to transport nospital for evaluation and				
	b. The investigators w MOT for Patient #5.	vere unable to locate an				
	7. On 02/28/23 at 2:30, Investigators #1 and #2 interviewed Staff #1101. The interview showed that an MOT should be filled out completely for every patient transported out of the hospital.					
	Item #3 - Access to E	mergency Medical Services				
	"Memorandum of Tran effective date 05/2019 showed that for all par medical condition that the appropriate equip	of the hospital's policy titled the hospital's policy titled the hospital property of the hospital does not have ment or staff to correct, an ent shall be performed, and add out as quickly as			PER CONTRACTOR CONTRAC	
	titled "South Sound Be	ne hospital's procedure ehavioral 9-1-1 EMS ID, no date, showed the				
	intake that Emergency have been dispatched	nursing staff will notify y Medical Services (EMS) I and where the patient is n prepares a staff escort.				

State Form 2567

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				<del></del>	c
war.		013319	B. WING		03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STATE	E, ZIP CODE	
SOUTH S	OUND BEHAVIORAL HO	SPITAL	DDLAND SQUARE WA 98503	LOOP SE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
L 335	Continued From page	e 7	L 335		
	greet Lacey Fire Crev	be ready at the door to ws and provide a staff escort d-in facility the whole time.			
	to be brought to the fi	oulatory/conscious, they are irst floor (exercise room) for afety of patients and 911			
	Lacey Fire Crews to a other patients do not Patients should be he	nse is necessary, escort appropriate unit and ask that wander around 911 crews. eld off either in their room or ever is furthest from Lacey			
	e. A nurse should be 911 response was ne communicate with La				
	f. Staff escort (nursing Fire from beginning to	g) should stay with Lacey o end of call.			
	Emergency Respons	e #1			
	call records and reco Communications (TC showed that on 12/09 staff called 911 for Pa responsive patient the reading of 51 before medication given to in glucose levels) and a hospital staff member located in unit 320-B repeat-back confirma	at had a blood glucose receiving IM glucagon (a ncrease a person's blood ppeared sweaty. The r stated that Patient #7 was three times, with tion, during the 911 call.			
	a. On 02/21/23, Investincident reports provi	stigators #1 and #2 reviewed ded by Lacey Fire			

State Form 2567

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
AIDIDIT	or contraction	IDERTIFICATION TO MIDERA	A. BUILDING:			
		013319	B. WING		03/0	; 19/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
SOUTH S	OUND BEHAVIORAL HO	SPITAL	LAND SQUAF	RE LOOP SE		
		LACEY, W	7	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
L 335	Continued From page	e 8	L 335			
	Department personne	el. The review showed that				
	when EMS arrived at	the hospital, they stood				
		doorbell. When a hospital				
		ed the door, they did not alled or where Patient #7				
	_	ormed the staff that they				
	were told 320-B was	the location of the patient.				
	-	mber took EMS to the unit,				
		ng the description of the 911 S were then escorted to				
	•	f on that unit directed them				
	to room 323, where P	atient #7 was located.				
	b. On 02/24/23 at 8:1	7 AM. Investigator #1				
		staff member (Staff #1110)				
		911 call for Patient #7. Staff				
		I how many minutes it took s to Patient #7 and stated				
		ence delays of 7 minutes or				
	longer before gaining	•				
	c. On 02/28/23 at 9:30	0 AM, Investigators #1 and				
		#1101 about the response				
		vas called. Staff #1101				
		was called, a staff member				
		s to take EMS to the patient ownstairs to meet EMS.				
	or bring the patient de	ownition to most wine.				
		10 AM, Investigators #1 and				
		nurse (Staff#1113). Staff en 911 was called, staff were				
		nt downstairs to meet EMS,				
	•	ole enough to get into a				
	wheelchair.					
	Emergency Response	e #2				
		tigators #1 and #2 reviewed				
		all logs provided by Lacey onnel and call records and				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		013319	B. WING		03/0	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
SOUTH S	OUND BEHAVIORAL HO	SPITAL	ODLAND SQUARE WA 98503	LOOP SE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 335	recordings from TCOI that on 12/23/22 at 8: dispatched to a 911 c Patient #5, a non-verl major depressive disc who had an unwitnes a. Lacey Fire Departr showed that EMS rep before gaining access evaluation. Patient #5 was transported to a Department (ED) for request.  b. On 02/28/23 at 5:1 interviewed an EMS s Staff #1109 confirmed the 911 call at the hos AM. Staff #1109 state and locked in the gyn minutes.  c. On 02/28/23 at 9:3 #2 interviewed Staff # from staff when 911 v stated that when 911 was to wait downstair or bring the patient downstairs was stable enough to Emergency Response	MM 911. The review showed 48 AM, EMS were all from the hospital for bal admitted patient with order and suicidal ideation sed fall.  Inent Incident Reports ported waiting 5 minutes and no obvious injuries and local Emergency evaluation at hospital staff's  5 PM, Investigator #1 staff member (Staff #1109). If that they had responded to epital on 12/23/22 at 8:48 and that they were left alone in to wait for Patient #5 for 5  O AM, Investigators #1 and #1101 about the response was called. Staff #1101 was called, a staff member as to take EMS to the patient bownstairs to meet EMS.  10 AM, Investigators #1 and #1113. Staff #1113 stated alled, staff were to transport as to meet EMS, if the patient of get into a wheelchair.	L 335			
	incident reports and o	call logs provided by Lacey				

State Form 2567

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED		
		•	D MANO	D MANG			
		013319	B. WING	·	03/09/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SOUTH S	SOUTH SOUND BEHAVIORAL HOSPITAL 605 WOOL			E LOOP SE			
LACEY, W			A 98503				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLE		
L 335	Continued From page	10	L 335				
	Fire Department pers recordings from TCOI that on 12/31/22 at 6: dispatched to a 911 c	onnel and call records and MM 911. The review showed 20 PM, EMS were all from the hospital for vho was suffering from drug					
	and waiting outside the before a hospital staff reported that they wa hospital staff to escor	nent Incident Reports orted ringing the doorbell he hospital for 4 minutes member let them in. EMS ited another 4 minutes for t them to Patient #8 (who elchair) in B-322, a delay of 8					
	b. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #8. The record showed that EMS arrived at the hospital at 6:31 PM and waited 4 minutes before gaining access to the facility, then waited another 4 minutes before gaining access to Patient #8, who had normal vital signs, had vomited and was shaking. Patient #8 was later transported to the ED via non-emergent ambulance transport.						
	interviewed an EMS s who responded to the #1111 stated that they before gaining access d. On 02/28/23 at 9:30 #2 interviewed Staff # from staff when 911 w stated that when 911 was to wait downstair	13 PM, Investigator #1 staff member (Staff #1111) 1911 call for Patient #8. Staff often wait 5 to 12 minutes 15 to patients at the hospital. 16 AM, Investigators #1 and 17 about the response 17 vas called. Staff #1101 18 was called, a staff member 18 to take EMS to the patient 18 wastairs to meet EMS.					

State Form 2567

State of \	<u> Washington</u>			_	•
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		013319	B. WING		C 03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE	•
SOUTH S	OUND BEHAVIORAL HO	SPITAL 605 WO	ODLAND SQUAR		
		LACEY,	WA 98503		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 335	Continued From page	e 11	L 335		
	#2 interviewed Staff # that when 911 was ca the patient downstairs	10 AM, Investigators #1 and #1113. Staff #1113 stated alled, staff were to transport s to meet EMS, if the patient get into a wheelchair.			
	Emergency Response	e #4			
	incident reports and of Fire Department pers recordings from TCO that on 01/15/23 at 9: dispatched to a 911 of Patient #9, a 63 year- of pneumonia (an infe oxygen saturation (a oxygen is traveling the history of chronic obs	call from the hospital for -old patient with a diagnosis ection in the lungs), a low measure of how much brough the body), and a structive pulmonary disease bry disease that obstructs			
	showed that EMS sta	ment Incident Reports ated that they rang the aited 4 minutes before ospital.			
	#2 reviewed hospital emergency response	53 AM, Investigators #1 and security footage of the to Patient #9 with the ng (Staff #1106). The review			
	i. At 9:46 AM, the EM pulling into the ambu	IS ambulance was seen lance entrance.			
	ii. At 9:47 AM, EMS v	were seen knocking on the			

State Form 2567

STATE FORM

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	;		35.25,101	**************************************	c
		013319	B. WNG		03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SOUTH SO	OUND BEHAVIORAL HO	SPITAL	DLAND SQUAR	E LOOP SE	·
		LACEY, W	/A 98503	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 335	Continued From page	e 12	L 335		
		al entrance door, which was S are then seen walking			
	iv. At 9:51 AM, EMS a	are seen entering the facility.			
	Lacey Fire Department Patient #9. The record at the hospital at 9:47 facility, then waited for who knew where Patierecord showed that Estate Patierecord showed the Estate Patierecord showed showed the Estate Patierecord showed showed showed showed showed	tigator #1 reviewed the nt Patient Care Record for d showed that EMS arrived AM, waited for entry to the ir a hospital staff member ent #9 was located. The MS gained access to I to evaluate and treat, a			
	d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.				
	#2 interviewed Staff # that when 911 was ca	10 AM, Investigators #1 and 1113. Staff #1113 stated Illed, staff were to transport to meet EMS, if the patient get into a wheelchair.			
	Emergency Response	e <b>#</b> 5			.
	incident reports and c Fire Department person recordings provided be showed that on 02/11/2 non-emergent ambulated Fire crews over their responses.	tigators #1 and #2 reviewed all logs provided by Lacey onnel and call records and y TCOMM 911. The review /23 at 11:06 PM, a ance crew contacted Lacey radio to inform that they al staff to evaluate Patient			

State Form 2567

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		С
		013319	To: MING		03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
SOUTH S	OUND BEHAVIORAL HOS	SPITAL 605 WOOI LACEY, W	DLAND SQUAR VA 98503	E LOOP SE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 335	#10 for respiratory disambulance crew was radio for further inform dispatched to the hos a. On 02/28/23 at 5:4 interviewed an EMS s who responded to the Staff #1112 stated that hospital, the non-emethat they were unable radio equipment to interviewed and they did not need their assessed Patient #100 b. On 03/01/23 at 11: #2 and Staff #1106 refootage of the emerged #10. The review show i. At 10:49 PM, the non-crew arrived at the facility doorbell.  iii. At 10:52 PM, the or facility doorbell.  iii. At 10:58 PM, the or facility doorbell.  iv. At 10:58 PM, the or facility and were seed contact Lacey Fire Cruy. Between 10:58 PM were observed walking and were seed contact Lacey Fire Cruy.	stress. The non-emergent unable to be reached over nation, and Lacey Fire Crew pital.  1 PM, Investigator #1 staff member (Staff #1112) or radio call for Patient #10. at when they arrived at the ergent crew informed them to get a signal on their form Lacey Fire Crews that it assistance, after they had deviewed hospital security ency response to Patient wed the following:  20	L 335	DEFICIENCY)	
	vi. At 11:03 PM, a ho	spital staff member rejoins			

State Form 2567

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		013319	B. WING		C	•
					03/09/2023	3
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
SOUTH S	OUND BEHAVIORAL HO	SPITAL 605 WOOI LACEY, W	LAND SQUAF	RE LOOP SE		
	OUR HADY OT		T	PROMETERS DI AN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ве сомг	(5) PLETE NTE
L 335	Continued From page	e 14	L 335			
	the crew and escorts	them through a door.				
	vii. At 11:12 PM, Lace arriving at the hospita	ey Fire Crews were seen al.				
		tigator #1 reviewed the nt Patient Care Record for ord showed that the			4444	
	for a patient who no le	ance crew arrived on scene onger required transport and ssess Patient #10, who had			e de la constante de la consta	
	a low oxygen saturati	on. Patient #10 was				
	assessed and found t and to be speaking in	o have normal vital signs full sentences.				
	d. On 02/28/23 at 9:3 #2 interviewed Staff #	0 AM, Investigators #1 and #1101 about the response was called. Staff #1101				
		was called, a staff member				
		s to take EMS to the patient ownstairs to meet EMS.				
	#2 interviewed Staff # that when 911 was ca	10 AM, Investigators #1 and 11113. Staff #1113 stated illed, staff were to transport s to meet EMS, if the patient				
	was stable enough to	get into a wheelchair.				
	Emergency Response	e #6				
	and incident reports p Department and call r	tigator #1 reviewed call logs provided by Lacey Fire ecords and recordings 911. The review showed 40 PM, EMS were				
	dispatched to a 911 c 34-year-old experience					
	a. Review of the 9-1-1	recording showed that -1 requesting assistance for				

State Form 2567

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					c
		013319	B. WNG		03/09/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
SOUTH S	OUND BEHAVIORAL HO	SPITAL 605 WOOI LACEY, W	DLAND SQUAR VA 98503	E LOOP SE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L 335	Continued From page	<del>2</del> 15	L 335		
	staff for the address a hospital. Dispatch per	11 is heard asking hospital and telephone number of the resonnel are heard confirming hospital staff are aware she sistance.			
	Staff #1106 reviewed	48 AM, Investigator #1 and hospital security footage of use to Patient #11. The llowing:			
	i. At 1:46 PM, the EM hospital.	S crew arrived at the			
	ii. At 1:47 PM, the EN at the hospital entran	1S crew were seen knocking ce door.			
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$		er a delay of 2.5 minutes, en opening the hospital			
	#2 interviewed Staff # from staff when 911 v stated that when 911 was to wait downstair	0 AM, Investigators #1 and #1101 about the response vas called. Staff #1101 was called, a staff member rs to take EMS to the patient ownstairs to meet EMS.			
	#2 interviewed Staff # that when 911 was ca the patient downstairs	10 AM, Investigators #1 and #1113. Staff #1113 stated alled, staff were to transport s to meet EMS, if the patient get into a wheelchair.			
	Emergency Respons	e #7			
	logs, incident reports provided by Lacey Fi	stigator #1 reviewed call , and Patient Care Records re Department and call gs provided by TCOMM 911.			

State Form 2567

State of V	Vashington	,	÷				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		A, BUILDING:	····	COMPLI	ETED
						c	;
		013319		B. WING		03/0	9/2023
NAME OF P	ROVIDER OR SUPPLIER	SI	TREET ADDF	RESS, CITY, STA	TE, ZIP CODE		
		6(	05 WOODL	AND SQUAR	E LOOP SE		
SOUTH SO	OUND BEHAVIORAL HO	SPITAL L	ACEY, WA	98503			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	,	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAO		•	ĺ	,,,,	DEFICIENCY)		
L 335	Continued From page	e 16		L. 335			
2 000	, -						
		hat on 02/25/23 at 11:35 P d to a 911 call from the	'M,				
	hospital for Patient #1						
		thdrawal symptoms with a					
	history of stroke and						
	0 00100100 144	.40 004 1	.				
		48 AM, Investigator #1 and hospital security footage of					
		onse to Patient #12. The	,				
	review showed the fo						
		· ·					
	-	MS crew were seen ringing	g				
ļ	the doorbell at the ho	spital entrance door.					
	ii. At 11:46 PM, after	a delay of 3 minutes.					
		en opening the hospital					
	door.		ŀ				
	; 						
		80 AM, Investigators #1 and				į	
	1	#1101 about the response was called. Staff #1101					
		was called, a staff member	er				
		rs to take EMS to the patie	t t				
	or bring the patient do	ownstairs to meet EMS.					
		40.11.1	.				
		:10 AM, Investigators #1 ar #1113. Staff #1113 stated	na				
		alled, staff were to transpo	rt l			ĺ	
		s to meet EMS, if the patie					
		get into a wheelchair.				ì	

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

Record apport
Salvac in 2
Allins

Statement of Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and	South Sound Behavioral Hospital (SSBH) is now in compliance with the Medicare Conditions of Participation as described in 42 CFR 482. SSBH protects the health and safety of the patients, staff and others.  The Governing Board called a special meeting	empilan providina emprijus emprijus empilan	covernent (Pi)  f Nucsing Officer  inft.  of the hospiter's	an consumetted  alto bos consenio  to bos consenio  velues manusod  selues manusod
accessing emergency supplies and equipment; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to implement policies and procedures, for the management of medical emergencies and transfers, to ensure staff completed and documented incident reports when medical emergencies occurred for 36 of 48 events (Item	on 3/2/2023. The findings from the initial WA state survey were discussed.  The policies and procedures were reviewed and determined to be appropriate. The breakdown in the hospital's lack of compliance was discussed. The hospital leadership committed to the Governing Board that the hospital staff will be reeducated and will be held responsible to perform their duties related to emergency	the Memoral prompt a	a 06, 2019, last showed that in a showed that in it in in it in	policy 10, effects reviewed 01/202 event of a medic as an unaccenter incident resort w documenting det
#1), completed and documented Memorandums of Transfer for 5 of 14 transferred patients (Patients #1, #2, #3, #4, and #5) (Item #2), and facilitated prompt access to Emergency Medical Services for 7 of 7 emergency responses reviewed (Patients #5, #7, #8, #9, #10, #11, and #12) (Item #3).	SSBH Chief Executive Officer (CEO) was held accountable to the Governing Board in developing the corrective action plan with help from his management team. The CEO presented the action plan in the Governing Board Meeting on 3/30/23. The CEO will be held accountable to	CEO	3/30/23	Approved Corrective Action Plan
Failure to implement policies and procedures for the management of medical emergencies and transfers risks patient harm from delayed or unmet care needs.  Findings included:	the Governing Board to ensure that SSBH maintains the corrective actions and complies with the Medicare Hospital Conditions of Participation.  The Action Plan was adjusted to ensure that it addressed all of the concerns received in the	Lall Delicion/I departmic setal facilitate complian promplia promplia promplia	receptionist will an ambutaneett econor in the bas ortment for greatment.	b. If directed, the district and salt for transpare the decrease of the decrea

## Item #1 - Incident Reports

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

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

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

- a. When screening a person that is not stable, the Nursing Supervisor will call the on-call physician to explain the situation and findings.
- b. If directed, the receptionist will call 911 and ask for an ambulance to transport the person to the hospital emergency department for assessment and treatment.

CMS letter dated 3/27/23. The Action Plan was reviewed in the Governing Board meeting held 3/30/23 at noon. The Governing Board reviewed, discussed and approved the action plan.

The action plan will be monitored as described, reported to the PI Committee, and presented to the Governing Board on a minimum of a monthly basis until the hospital is 100% in compliance for 6 continuous months of providing consistent and timely access to emergency services.

This is evidenced through completed documentation of incident reports when medical emergencies occur, completed Memorandum of Transfers (MOT) for transferred patients, and documentation of prompt access to Emergency Services in Code Blue documentation, and completion of New MOT Debrief/Review form .

All emergency services occurring at SSBH are reported to the CEO/AOC ASAP by intake director and/or house supervisor. The PI Director /designee will review the Incident Report and all supporting documentation (example MOT/ Code Blue sheet, emergency call log, documentation) and reports this to the CEO. This is also recorded in the PI Dashboard. The Emergency Services response will be evaluated daily by the CNO/designee to ensure timely EMT entry, completion of New MOT Debrief/Review form completed by the nursing department that records SSBH response time to facilitate EMS access to the facility. For noncompliance the CNO/ designee will follow up promptly with the staff involved to review the process and provide documentation of the

- c. Staff will complete an incident report and route it to the PI Director.
- 2. On 03/09/23, Investigators #1 and #2 reviewed an event log of all Lacev Fire Department 911 (emergency) responses to the hospital between 12/02/22 and 03/02/23 and a hospital incident report log of all incident reports between 12/01/22 and 03/08/23. The review showed the following:
  - a. There were 48 emergency responses from Lacey Fire Department to the hospital between 12/02/22 and 03/02/23.
  - b. b. Of the 48 emergency responses to the hospital, 36 were missing corresponding hospital incident reports.
  - c. c. On 02/28/23 at 2:30 PM, Investigators #1 and #2 interviewed the Chief Nursing Office (CNO).

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

### Item #2 Memorandums of Transfer

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

follow up and re-education.

Governing Board approved new quality indicators consistent with monitoring timely response to emergency services and compliance of documentation required. The PI Director will report the results of the indicators in the monthly PI. The CEO will report the information to the Governing Board on a minimum of a monthly basis. The following are the new quality indicators.

- 1. Pl Director will ensure daily that log for all emergency call is complete. Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.
- 2. PI Director will ensure daily through nursing flash meetings that an incident report for every emergency call is completed. Compliance will be monitored with a 100% threshold for 6 consecutive months.
- 3. PI Director will ensure daily that fully completed MOT documentation for all emergency transfers are documented. Compliance will be monitored with a 100% threshold for 6 consecutive months.
- 4. CNO/intake Director/Designee will monitor SSBH response time to ensure timely EMT entry through New MOT Debrief/Review completed by nursing department daily in the nursing flash meeting and will be reported monthly in the committee of the whole.

For non-compliance the PI Director/CNO/Intake

PI Director 3/30/2023 Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.

3/14/2023

3/30/2023

3/30/2023

3/30/2023

Pl Director

PI Director

CNO/Intake

Director

Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.

**CEO Monthly Report to** 

**Governing Board** 

Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.

Daily Audit and Compliance will be monitored with a 100% threshold on completeness for 6 consecutive months.

These indicators will be reported to governing board until 100% compliance is achieved for 6 consecutive months. then will monitor quarterly for sustained compliance.

Director will follow up promptly with the staff involved to review the process and provide documentation of the follow up and reeducation.

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

### Patient #2

- 3. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following:
  - a. On 02/26/23, Patient #2 presented to intake after a suicide attempt and refused to be a voluntary admission. Patient #2 was transported to another facility by ambulance at 3:18 PM and an MOT was retained in the file.
  - Review of the MOT showed that no physician certification signature was documented on the form.
  - c. Staff #1104 confirmed the investigators finding of the missing documentation.

### Patient #3

- 4. On 02/28/23 at 2:00 PM, Investigators #1 and #2, Staff #1104 and Staff #1105 reviewed the MOT file for the month of 02/23. The review showed the following:
  - a. On 02/28/23, Patient #3 presented to intake requesting alcohol detoxification and was found to have an elevated blood pressure and heart rate. Patient #3 was transported to another facility at an unknown time and an MOT was retained in the file.
  - Review of the MOT showed that no physician certification signature, no accepting facility, no mode of transport, and no patient consent

clearly delegate escort to ensure dedicated person who will facilitate prompt access to the unit. This assignment sheet will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100% threshold.

**CNO** 

CNO

3/30/2023

3/30/2023

- MOT Debrief /Review was devised to track promptness of access to the unit. This MOT Debrief/Review will be submitted to the CNO to ensure compliance. Compliance will be monitored weekly with a 100%. threshold.
- 4. A monthly hospital wide "Code Blue" Drill will be conducted by hospital leadership to ensure that staff are following policies and procedures. A "Code Blue" critique form will be submitted to the CNO for review.
- Nursing flash agenda was revised on 3/28/2023 to reflect medical emergencies as an item to be reviewed with units.

All data gathered will be presented by the CNO to the governing board monthly. For non-compliance the CNO/ designee will follow up promptly with the staff involved to review the process and provide documentation of the follow up and re-education.

Daily audit. This assignment sheet will be submitted to the CNO to ensure compliance.
Compliance will be monitored weekly with a 100% threshold for 6 months.

Daily audit. This assignment sheet will be submitted to the CNO to ensure compliance.
Compliance will be monitored weekly with a 100% threshold for 6 months.

Monthly Drill and Code
Blue Drill Documentation
for 6 months.

**Daily Nursing Flash** 

All data gathered will be presented by the CNO to the governing board monthly. Threshold will be 100% compliance for 6 months. For noncompliance the CNO/designee will follow up promptly with the staff involved to review the process and provide documentation of the

\*

signature were documented on the form.  c. Staff #1104 confirmed the		follow up and re education.
investigators findings of the missing documentation.		
Patient #4		EPirawwo-duinwo
5. On 02/28/23 at 2:00 PM, Investigators		
#1 and #2, Staff #1104 and Staff #1105		
reviewed the MOT file for the month		it out the same of
of 02/23. The review showed the		
following:	and the second s	
	conveniency	
a. On 02/27/23, Patient #4 presented	**E_A**********************************	
to intake requested admission for	04,000-050-07	TMI
suicidal ideation and was found to	TO CLOTHAND	
be dependent on a caregiver for	Mademoral	i.
bathroom and showering needs.	Convidence .	
Patient #4 was transported to an unknown facility at an unknown	2	
time.		
b. The investigators were unable to		
locate an MOT for Patient #4.		
C. Staff #1104 confirmed the		
investigators finding of the missing	CO.A.A.A.B.	
MOT.		
Patient #5		
6. On 02/28/23 at 3:00 PM, Investigators		
#1 and #2 reviewed the medical record		
of Patient #5, a non-verbal admitted		
patient with major depressive disorder		
and suicidal ideation. The review		
showed the following:		. The second sec
a. On 12/23/22 at 8:30 AM, Patient #5		anavinerre
had an unwitnessed fall and 911	Mark and	Servinista
was called to transport the patient		egyriggswall
to a local hospital for evaluation		12.55774335000
and treatment.		***************************************

- b. The investigators were unable to locate an MOT for Patient #5.
- 7. On 02/28/23 at 2:30, Investigators #1 and #2 interviewed Staff #1101. The interview showed that an MOT should be filled out completely for every patient transported out of the hospital.

Item #3 - Access to Emergency Medical Services

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

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

- a. When 911 is called, nursing staff will notify intake that Emergency Medical Services (EMS) have been dispatched and where the patient is located while the team prepares a staff escort.
- b. Intake staff should be ready at the door to greet Lacey Fire Crews and

•	ند <b>ب</b>	A <sup>*</sup>	<b>v</b>	<b>9</b> 3°	`\$P	*	¥
provide a staff escort throughout							
the locked-in facility the whole							
time.							
c. If the patient is							
ambulatory/conscious, they are to		•					
be brought to the first floor				;			
(exercise room) for patient privacy		•					
and safety of patients and 911							
crews.							
d. If a unit floor response is							
necessary, escort Lacey Fire Crews							
to appropriate unit and ask that							
other patients do not wander							
around 911 crews. Patients should				1			
be held off either in their room or							
common area; whichever is		•					
furthest from Lacey Fire Crews.							
e. A nurse should be available to				-			
describe why a 911 response was							
necessary and to communicate				27			
with Lacey Fire Crews.				S. Carrier and C. Car			
f. Staff escort (nursing) should stay							
with Lacey Fire from beginning to							
end of call.				-			
Emergency Response #1							
2. On 02/22/23, Investigators #1 and #2							
reviewed call records and recordings							
from Thurston 911 Communications							
(TCOMM 911). The review showed that	:						
on 12/09/22 at 5:36 PM, hospital staff	· ·						
called 911 for Patient #7, a minimally							
responsive patient that had a blood							
glucose reading of 51 before receiving IM glucagon (a medication given to							
increase a person's blood glucose		•		į			
levels) and appeared sweaty. The							
hospital staff member stated that					:		
nospitai stan member stateu mat			:				

Patient #7 was located in unit 320-B

three times, with repeat-back confirmation, during the 911 call.  a. On 02/21/23, Investigators #1 and #2 reviewed incident reports provided by Lacey Fire Department personnel. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorfell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
a. On 02/21/23, Investigators #1 and #2 reviewed incident reports provided by Lacey Fire Department personnel. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 30-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
reviewed incident reports provided by Lacey Fire Department personnei. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	]
Lacey Fire Department personnel. The review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
review showed that when EMS arrived at the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
the hospital, they stood outside and rang the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	- 1
the doorbell. When a hospital staff member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
member answered the door, they did not know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
know why 911 was called or where Patient #7 was located. EMS informed the staff that they were told 320-8 was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
#7 was located. EMS informed the staff that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
that they were told 320-B was the location of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	I
of the patient. The hospital staff member took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
took EMS to the unit, but no patient matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
matching the description of the 911 call was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
was present. EMS were then escorted to another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
another unit, and staff on that unit directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
directed them to room 323, where Patient #7 was located.  b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
#7 was located. b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
b. On 02/24/23 at 8:17 AM, Investigator #1 interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
interviewed an EMS staff member (Staff #1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
#1110) who responded to the 911 call for Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
Patient #7. Staff #1110 could not recall how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
how many minutes it took before gaining access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
access to Patient #7 and stated that they often experience delays of 7 minutes or longer before gaining access to a patient.	
often experience delays of 7 minutes or longer before gaining access to a patient.	
longer before gaining access to a patient.	
0.00 (20 (22 at 0.20 ANA transpirators 44	
c. On 02/28/23 at 9:30 AM, Investigators #1	. 1
and #2 interviewed Staff #1101 about the	Marine y
response from staff when 911 was called.	
Staff #1101 stated that when 911 was	
called, a staff member was to wait	
downstairs to take EMS to the patient or	
bring the patient downstairs to meet EMS.	
d. On 02/28/23 at 10:10 AM, Investigators	
#1 and #2 interviewed a staff nurse (Staff	
#1113). Staff #1113 stated that when 911	
was called, staff were to transport the	
patient downstairs to meet EMS, if the	

e e e e e e

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

فود

**.**..

downstairs to take EMS to the					
patient or bring the patient					
downstairs to meet EMS.	1				
d. On 02/28/23 at 10:10 AM,					}
Investigators #1 and #2 interviewed					
Staff #1113. Staff #1113 stated that					
when 911 was called, staff were to					
transport the patient downstairs to					
meet EMS, if the patient was stable					
enough to get into a wheelchair.					
Emergency Response #3					
4. On 02/21/23, Investigators #1 and #2					
reviewed incident reports and call logs					Newport of
provided by Lacey Fire Department					
personnel and call records and recordings					
from TCOMM 911. The review showed					
that on 12/31/22 at 6:20 PM, EMS were					
dispatched to a 911 call from the hospital					
for Patient #8, a patient who was					
suffering from drug withdrawal and					
decreased level of consciousness.					
a. Lacey Fire Department Incident					
Reports showed that EMS reported		ı			
ringing the doorbell and waiting		:			
outside the hospital for 4 minutes		•			
before a hospital staff member let		·			**
them in. EMS reported that they waited					· Second
another 4 minutes for hospital staff to					-107
escort them to Patient #8 (who was					
waiting in a wheelchair) in B-322, a					
delay of 8 minutes.					
			I .	ı	

b. On 03/02/23, Investigator #1 reviewed the Lacey Fire Department Patient Care Record for Patient #8. The record showed that EMS arrived at the hospital at 6:31 PM and waited 4 minutes before gaining access to the facility, then waited another 4 minutes

- before gaining access to Patient #8, who had normal vital signs, had vomited and was shaking. Patient #8 was later transported to the ED via non-emergent ambulance transport.
- c. On 02/24/23 at 11:13 PM, Investigator #1 interviewed an EMS staff member (Staff #1111) who responded to the 911 call for Patient #8. Staff #1111 stated that they often wait 5 to 12 minutes before gaining access to patients at the hospital.
- d. On 02/28/23 at 9:30 AM, Investigators #1 and #2 interviewed Staff #1101 about the response from staff when 911 was called. Staff #1101 stated that when 911 was called, a staff member was to wait downstairs to take EMS to the patient or bring the patient downstairs to meet EMS.
- e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

# Emergency Response #4

5. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings from TCOMM 911. The review showed that on 01/15/23 at 9:41 AM, EMS were dispatched to a 911 call from the hospital for Patient #9, a 63 year-old patient with a diagnosis of pneumonia (an infection in the lungs), a

low oxygen saturation (a measure of				
how much oxygen is traveling through			OF THE PARTY OF TH	
the body), and a history of chronic			1000	
obstructive pulmonary disease (a			ALC:	
chronic inflammatory disease that				
obstructs airflow from the lungs).				No.
a. Lacey Fire Department Incident				He care the care
Reports showed that EMS stated that	The state of the s			*ACCES
they rang the doorbell twice and				
waited 4 minutes before gaining				A TOTAL STATE OF THE STATE OF T
entry to the hospital.				of the state of th
b. On 03/01/23 at 11:53 AM,				OCCUPATION AND ADMINISTRATION AN
Investigators #1 and #2 reviewed	·			
hospital security footage of the				"
emergency response to Patient #9	-			Sample grant of the same of th
with the former Chief of Nursing	resolution for			v ranczew.
(Staff #1106). The review showed the	TO ALLEGEMENT			esperiin aaraa
following:	The state of the s			is some entremental and the second
i. At 9:46 AM, the EMS ambulance	Z. Albanowski			III.71 G III 47 F
was seen pulling into the	Assessment			измет. Измет
ambulance entrance.	DEBANGE OF THE PROPERTY OF THE			and the second s
ii. At 9:47 AM, EMS were seen	THE CHARLES AND ADDRESS AND AD			V.III. ON THE STATE OF THE STAT
knocking on the hospital entrance				
door.				TOTAL DE LA CALLESTICA DE
iii. At 9:50 AM, EMS were seen				PANIAMENTAL
ringing the doorbell at the hospital	And the second s			
entrance door, which was then				
opened, and EMS are then seen	N. Control of the Con			.
walking towards another door	court Production			····· r
several feet away.				
iv. At 9:51 AM, EMS are seen				N. C.
entering the facility.	MA CONTRACTOR OF THE CONTRACTO			***************************************
c. On 03/02/23, Investigator #1	AT THE PARTY OF TH			Bilines
reviewed the Lacey Fire Department	777-027-02	·		сехнаша
Patient Care Record for Patient #9.				000 A mm A 400 Mm
The record showed that EMS arrived				мином в
at the hospital at 9:47 AM, waited for				Elifornia de la companya de la compa
entry to the facility, then waited for a				The state of the s
hospital staff member who knew				**************************************

where Patient #9 was located. The

- record showed that EMS gained access to Patient #9 at 9:55 AM to evaluate and treat, a delay of 8 minutes.
- d. On 02/28/23 at 9:30 AM,
  Investigators #1 and #2 interviewed
  Staff #1101 about the response from
  staff when 911 was called. Staff
  #1101 stated that when 911 was
  called, a staff member was to wait
  downstairs to take EMS to the patient
  or bring the patient downstairs to
  meet EMS.
- e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

# **Emergency Response #5**

- 6. On 02/21/23, Investigators #1 and #2 reviewed incident reports and call logs provided by Lacey Fire Department personnel and call records and recordings provided by TCOMM 911. The review showed that on 02/11/23 at 11:06 PM, a non-emergent ambulance crew contacted Lacey Fire crews over their radio to inform that they were asked by hospital staff to evaluate Patient #10 for respiratory distress. The non-emergent ambulance crew was unable to be reached over radio for further information, and Lacey Fire Crew dispatched to the hospital.
  - a. On 02/28/23 at 5:41 PM, Investigator #1 interviewed an EMS staff member

(Staff #1112) who responded to the				
radio call for Patient #10. Staff #1112				· ·
stated that when they arrived at the				
hospital, the non-emergent crew				
informed them that they were unable				
to get a signal on their radio				
equipment to inform Lacey Fire Crews				
that they did not need their				
assistance, after they had assessed				Till de de la constant de la constan
Patient #10.	·			
b. On 03/01/23 at 11:53 AM,		-		Proposition of the Control of the Co
Investigators #1 and #2 and Staff				
#1106 reviewed hospital security				
footage of the emergency response to				
Patient #10. The review showed the				· · · · · · · · · · · · · · · · · · ·
following:				
i. At 10:49 PM, the non-emergency		:		
ambulance crew arrived at the		:		to de control de contr
facility.			•	
ii. At 10:52 PM, the crew were seen				
ringing the facility doorbell.				
iii. At 10:56 PM, the door was opened				
by a hospital staff member who has				
a short conversation with the crew.				
iv. At 10:58 PM, the crew were left				t Programme
alone in the hallway and were seen				NACHINI PARA PARA PARA PARA PARA PARA PARA PAR
using their radio to contact Lacey Fire Crews.				
v. Between 10:58 PM and 11:03 PM,	l de la companya de			· .
the crew were observed walking to				Note: 1
different doors in the hallway and	· · · · · · · · · · · · · · · · · · ·			
knocking on the door the hospital	· 			The section is a second section of the second section of the section is a second section of the
staff member had gone through.				
vi. At 11:03 PM, a hospital staff				No. or the state of the state o
member rejoins the crew and	l e e e e e e e e e e e e e e e e e e e			A CONTRACTOR OF THE CONTRACTOR
escorts them through a door.				A PARTICULAR AND A PART
vii. At 11:12 PM, Lacey Fire Crews				
were seen arriving at the hospital.	!			A CANADA
c. On 03/02/23, Investigator #1		Reading States		u.g. Bran
reviewed the Lacey Fire Department	i İ	walk outlines		

.14

,et

, re

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

- d. On 02/28/23 at 9:30 AM,
  Investigators #1 and #2 interviewed
  Staff #1101 about the response from
  staff when 911 was called. Staff
  #1101 stated that when 911 was
  called, a staff member was to wait
  downstairs to take EMS to the
  patient or bring the patient
  downstairs to meet EMS.
- e. On 02/28/23 at 10:10 AM, Investigators #1 and #2 interviewed Staff #1113. Staff #1113 stated that when 911 was called, staff were to transport the patient downstairs to meet EMS, if the patient was stable enough to get into a wheelchair.

# **Emergency Response #6**

- 7. On 03/10/23, Investigator #1 reviewed call logs and incident reports provided by Lacey Fire Department and call records and recordings provided by TCOMM 911. The review showed that on 02/15/23 at 1:40 PM, EMS were dispatched to a 911 call for Patient #11, a 34-year-old experiencing chest pain.
  - a. Review of the 9-1-1 recording showed that Patient #11 called 9-1-1 requesting assistance for chest pain.

		•			•	
Patient #11 is heard asking hospital						
staff for the address and telephone						l I
number of the hospital. Dispatch	•					
personnel are heard confirming with						
Patient #11 that hospital staff are						
aware she is calling 9-1-1 for						
assistance.						
b. On 03/09/23 at 11:48 AM,						
Investigator #1 and Staff #1106						
reviewed hospital security footage						
of the emergency response to						
Patient #11. The review showed the						
following:						
i. At 1:46 PM, the EMS crew arrived						
at the hospital.						· · ·
ii. At 1:47 PM, the EMS crew were			i			
seen knocking at the hospital			Ì			
entrance door.						
iii. At 1:49:30 PM, after a delay of						
2.5 minutes, hospital staff were						
seen opening the hospital door.						
c. On 02/28/23 at 9:30 AM,						
Investigators #1 and #2 interviewed						
Staff #1101 about the response from						
staff when 911 was called. Staff						
#1101 stated that when 911 was						
called, a staff member was to wait						1
downstairs to take EMS to the						1
patient or bring the patient			•			~
downstairs to meet EMS. d. On 02/28/23 at 10:10 AM,				į		
Investigators #1 and #2						1
interviewed Staff #1113. Staff			-			
#1113 stated that when 911 was						
called, staff were to transport the						
patient downstairs to meet EMS, if						
the patient was stable enough to						
get into a wheelchair.						
977						
Emergency Response #7						

		Territor Company	
8. On 03/10/23, Investigator #1 reviewed			
call logs, incident reports, and Patient			
Care Records provided by Lacey Fire	. !	San Control	
Department and call records and	·	II-	
recordings provided by TCOMM 911.			
The review showed that on 02/25/23 at			
11:35 PM, EMS were dispatched to a		Section 2015	
911 call from the hospital for Patient	1		
#12, a 38-year-old experiencing drug	:		
withdrawal symptoms with a history of		ANALYSIS CONTRACTOR OF THE PROPERTY OF THE PRO	
stroke and seizures.		November III on	The state of the s
a. On 03/09/23 at 11:48 AM,		Price and the second se	
Investigator #1 and Staff #1106	•	001001001001001001001001001001001001001	
reviewed hospital security footage of			
the emergency response to Patient			
#12. The review showed the following:			
i. At 11:43 PM, the EMS crew were			
seen ringing the doorbell at the	!		
hospital entrance door.	, 		
ii. At 11:46 PM, after a delay of 3	· ·		
minutes, hospital staff were seen			
opening the hospital door.			
b. On 02/28/23 at 9:30 AM,			
Investigators #1 and #2 interviewed		All revisions	
Staff #1101 about the response from			
staff when 911 was called. Staff #1101	·		
stated that when 911 was called, a			
staff member was to wait downstairs	,		
to take EMS to the patient or bring the			
patient downstairs to meet EMS.			
c. On 02/28/23 at 10:10 AM,			
Investigators #1 and #2 interviewed			
Staff #1113. Staff #1113 stated that			4
when 911 was called, staff were to			
transport the patient downstairs to			
meet EMS, if the patient was stable			
enough to get into a wheelchair.			

•		,		
				1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
,				
	•			
30 July 20 Jul				
citomontonio				
CONTRACTOR CONTRACTOR				
EX. CHARGO CONTRACTOR				٠.
Į			the state of the s	

Terrance J O'Reilly CEO

Date



PO Box 47874 • Olympia, Washington 98504-7874

04/11/2023

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

Re: Complaint #128197/2023-236

Dear Mr. O'Reilly,

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

A Progress Report is due on or before 05/08/23 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

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

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

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

Sincerely,

Starla Tillinghast, BSN, RN Nurse Consultant Investigator