STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

November 5, 2018

Smokey Point Behavioral Hospital
3955 156th ST NE
Marysville, WA 98271-4831

Dear Ms. Schneider

This letter contains information regarding the recent investigation of Smokey Point Behavioral Hospital by the Washington State Department of Health. Your Washington State licensing investigation was completed on October 10, 2018

During the investigation, deficient practice was found in the areas listed on the attached Statement of Deficiencies. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 14 days after you receive this letter.

Each plan of correction statement must include the following:

- The regulation number;
- How the deficiency will be corrected;
- Who is responsible for making the correction;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations.

You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return the original reports and Plans of Correction to the following address:

Gina L. Dick, LMHC, CDP, MHP, MAC
Department of Health, Investigations and Inspections Office
P.O. Box 47874
Olympia, WA 98504-7874

Please contact me if there are questions regarding the investigation process, deficiencies cited, or completion of the Plans of Correction. I may be reached at (360)236-2981 or by email at Gina.dick@doh.wa.gov.

I want to extend another "thank you" to you and to everyone that assisted me during the investigation.

Gina L. Dick, LMHC, CDP, MHP, MAC
Behavioral Health Reviewer
Enclosures: DOH Statement of Deficiencies
Plan of Correction Brochure

Behavioral Health Agency Inspection Report

Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
TEL: 360-236-4732

Smokey Point Behavioral Hospital, 3955 156th ST NE, Marysville, WA 98271-4831 Agency Name and Address		Sally Ann Schneider Administrator
Investigation Inspection Type	October 8-10, 2018 Investigation Onsite Dates	Gina L. Dick Investigator
2018-11858 Case Number	BHA.FS. 60874194 License Number	Behavioral Health Hospital E & T BHA Agency Services Type

Please note that the deficiencies/violations/observations noted in this report are not all-inclusive, but rather were deficiencies/violations/observations that were observed or discovered during the on-site inspection.

Deficiency Number and Rule Reference	Observation Findings	Plan of Correction
WAC 246-341-1126(4)(d) Mental health inpatient services-Policies and Procedures - Adult. In addition to meeting the agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-341-0650, and the applicable inpatient service requirements in WAC 246-341-1118 through 246-341-1132, an inpatient facility must implement all of the following administrative requirements: **(4)** A policy management structure that establishes: **(d)** Procedures to inventory and safeguard the personal property of the individual being detained according to RCW 71.05.220;	The Washington State Administrative Code is not met as evidenced by: Based on clinical record review it was determined the agency failed to follow the agencies "unclothed body search/property search" policy and procedures at intake resulting in the client possessing and using a syringe reportedly filled with methamphetamine after admission to the unit. Failure of the agency to follow the agency policy and procedure of body and property search resulted in harm to the patent because of the patient's use of methamphetamine, causing methamphetamine intoxication, and demonstrating erratic behavior. Failure to follow the agency policy and procedure placed other patients at significant risk of harm due the potential of other patients having access to the syringe and methamphetamine. Findings included: 1. Review of the clinical record on October 8, 2018 determined the patient admitted on August 4, 2018 did not have a complete search of their person or belongings as evidenced by the patient belongings examination & inventory sheet completed by staff stating "patient refused" and staff not searching belongings. 2. Review of clinical record determined on August 6, 2018 a progress note indicated erratic behavior by the client prompting a patient room search resulting in a found syringe. On October 8, 2018 at 3:00pm when interviewed Ryan Robertson indicated, the incident report for the August 6, 2018 incident could not be found. He requested a staff member who was present during the incident write a	**Regulation Number-WAC 246-341-1126(4)(d)** **Plan of Correction for Each specific deficiency Cited:** The hospital failed to detect contraband in July. A second incident report was created when the first report could not be located, When identified by DOH Hospital bed surveyors. **Procedure/process for implementing the plan of correction:** • RN's, LPN's, and MHT's were retrained by the CNO/ Nurse Designee on 5 identified areas including but not limited to the room searches per policy are conducted twice a day to ensure that mitigation plans have taken place for safety of the unit and patients. This occurred on 8-6-2018 through 8-9-2018, prior to working their first shift since the changes. Included in the training process's and implementations: o Intake- Wanding with metal detector has commenced for every patient brought into the facility. Belongings are inventoried and searched for contraband. o Admission-Wanding occurs with a metal detector and belongings inventoried/searched for any contraband. All items coming in with the patient are closely inspected. A full body search of every patient admitted is part of the screening for contraband. The patient undergoes skin check and inspection of contraband on the body

	second version and place in the incident manual.	completed at this time. ○ On Unit- Utensils are carefully monitored by staff. Staff complete an inventory of utensils when handed out and patients with utensils are within view of staff. Additional mitigation for any hidden contraband includes conducting room searches of every room, This includes looking in patient belongings in their room. Patients suspected of having hidden contraband will be searched on person for any contraband when returning from the cafe, and a full body search is conducted by provider order of any patient believed hiding contraband after being off unit. ○ Cafeteria- Utensils are monitored and inventoried when returned after meals to ensure the utensil is whole when returned to safe guard against any type of contraband returning to the unit. A designated staff person stands by at the garbage receptacle to ensure patients do not attempt to remove an item of contraband. A staff person is always during meals and conducts rounds close to the patients during meals in the cafeteria to ensure no self-harming behavior or hiding of contraband occurs. ○ Visits- All visitors are wanded with a metal detector prior to leaving the

		lobby to ensure contraband is not being smuggled in. Belongings brought in by visitors are searched. Security personnel are present for visiting hours to ensure no contraband items are being handed off. If it is known that a visitor has given contraband to a patient, the treatment team and provider are to determine if the visitor will no longer be allowed to vis or if visiting is restricted. o Twice a day room searches of all rooms are conducted to ensure for a second time that no contraband is missed. • Staff training included: o Handouts o Post tests o Competencies are conducted per the post test and repetitive return demonstrations conducted as part of the competencies. o Class Room Training and for those who were unable to attend classroom, 1:1 training was given. • To ensure continual compliance competency is evaluated by the auditors to assure compliance and accountability including counseling and return demonstration during audits. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Any contraband found is reported in an incident report and an

		investigation is conducted.
		• Monthly staff meetings take place to ensure communication to the staff regarding compliance. This took place on 7/31/18 and 8/1/18 at three separate times. Meeting will continue monthly to ensure communication, safety and compliance.
		• All incident reports are reported to senior leadership through the communication process. This includes findings, follow-up and any questioned results by the board.
		
		• Staff who do not follow procedure are held accountable through coaching and the disciplinary process.
		• A member of the nursing leadership team are to be personally present for At least one the unclothed skin checks depending on admissions and orders, and 10% of room searches weekly.
		• Staff who fail to follow the correct procedure will receive disciplinary action, up to and including termination.
		• Audits 5 days a week conducted to include:
		  ○ Admission belongings inspections to ensure staff compliance with CAP
		  ○ 5 meals weekly in cafeteria to ensure staff compliance with CAP
		  ○ At least 2 family visitations weekly in cafeteria to ensure compliance with CAP.
		
		Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to

		prevent the likelihood of re-occurrence of the deficient practice: • The CNO/Nurse designee will issue weekly reports of compliance to the Governing Board at the weekly communication meeting. • Audits are to continue until 100% compliance has been achieved for 90 days continuously. Additional corrective actions needed will be discussed in the weekly Governing Board communication. Results for QAPI will also be reported to the PI committee to ensure compliance with tracking and any further enhancements to the plan of correction. • A compliance rating of 98% is the selected threshold for the weekly audits. If this threshold is not reached, the CAP will be reviewed and/or revised to include new measures to ensure compliance. • When 100% compliance has been achieved for 90 days.. **Individual Responsible:** • CNO/ Nurse Designee **Date Training Completed:** 8/9/2018 **Date Audits completed:** 11/9/2018

71.05.220 **Property of committed person.** At the time a person is involuntarily admitted to an evaluation and treatment facility, secure detoxification facility, or approved substance use disorder treatment program, the professional person in charge or his or her designee shall take reasonable precautions to inventory and safeguard the personal property of the person detained. A copy of the inventory, signed by the staff member making it, shall be given to the person detained and shall, in addition, be open to inspection to any responsible relative, subject to limitations, if any, specifically imposed by the detained person. For purposes of this section, "responsible relative" includes the guardian, conservator, attorney, spouse, parent, adult child, or adult brother or sister of the person. The facility shall not disclose the contents of the inventory to any other person without the consent of the patient or order of the court	RCW 71.05.220 Property of committed person is not met as evidenced by: Based on clinical record review it was determined the agency failed to follow the agencies "unclothed body search/property search" policy and procedures at intake resulting in the client possessing and using a syringe reportedly filled with methamphetamine after admission to the unit. Failure of the agency to follow the agency policy and procedure of body and property search resulted in harm to the patent because of the patient's use of methamphetamine, causing methamphetamine intoxication, and demonstrating erratic behavior. Findings included: 3. Review of Review of the clinical record on October 8, 2018 determined the patient admitted on August 4, 2018 did not have a complete search of their person or belongings as evidenced by the patient belongings examination & inventory sheet completed by staff stating "patient refused" and staff not searching belongings. 1. Based on clinical record review there was no evidence of further attempts to get the patient information documented on the patient belongings form.	Regulation Number- **71.05.220** **Plan of Correction for Each specific deficiency Cited:** The hospital failed to detect contraband in July. **Procedure/process for implementing the plan of correction:** • RN's, LPN's, and MHT's were retrained by the CNO/ Nurse Designee on 5 identified areas including but not limited to the room searches per policy are conducted twice a day to ensure that mitigation plans have taken place for safety of the unit and patients. This occurred on 8-6-2018 through 8-9-2018, prior to working their first shift since the changes. Included in the training process's and implementations: o Intake- Wanding with metal detector has commenced for every patient brought into the facility. Belongings are inventoried and searched for contraband. o Admission-Wanding occurs with a metal detector and belongings inventoried/searched for an contraband. All items coming in with the patient are closely inspected. A full body search of every patient admitted is part of the screening for contraband. The patient undergoes skin check and inspection of contraband on the body completed at this time. o On Unit- Utensils are carefully monitored by staff. Staff complete an inventory

		of utensils when handed out and patients with utensils are within view of staff. Additional mitigation for any hidden contraband includes conducting room searches of every room, This includes looking in patient belongings in their room. Patients suspected of having hidden contraband will be searched on person for any contraband when returning from the cafe, and a full body search is conducted by provider order of any patient believed hiding contraband after being off unit. o Cafeteria- Utensils are monitored and inventoried when returned after meals to ensure the utensil is whole when returned to safe guard against any type of contraband returning to the unit. A designated staff person stands by at the garbage receptacle to ensure patients do not attempt to remove an item of contraband. A staff person is always during meals and conducts rounds close to the patients during meals in the cafeteria to ensure no self-harming behavior or hiding of contraband occurs. o Visits- All visitors are wanded with a metal detector prior to leaving the lobby to ensure contraband is not being smuggled in. Belongings brought in by

		visitors are searched. Security personnel are present for visiting hours to ensure no contraband items are being handed off. If it is known that a visitor has given contraband to a patient, the treatment team and provider are to determine if the visitor will no longer be allowed to visit, or if visiting is restricted. o Twice a day room searches of all rooms are conducted to ensure for a second time that no contraband is missed. • Staff training included: o Handouts o Post tests o Competencies are conducted per the post test and repetitive return demonstrations conducted as part of the competencies. o Class Room Training and for those who were unable to attend classroom, 1:1 training was given. • To ensure continual compliance competency is evaluated by the auditors to assure compliance and accountability including counseling and return demonstration during audits. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Any contraband found is reported in an incident report and an investigation is conducted. • Monthly staff meetings take place to ensure communication to the staff

		regarding compliance. This took place on 7/31/18 and 8/1/18 at three separate times. Meeting will continue monthly to ensure communication, safety and compliance. • All incident reports are reported to senior leadership through the communication process. This includes findings, follow-up and any questioned results by the board. • Staff who do not follow procedure are held accountable through coaching and the disciplinary process. • A member of the nursing leadership team are to be personally present for At least one the unclothed skin checks depending on admissions and orders, and 10% of room searches weekly. • Staff who fail to follow the correct procedure will receive disciplinary action, up to and including termination. • Audits 5 days a week conducted to include: o Admission belongings inspections to ensure staff compliance with CAP o 5 meals weekly in cafeteria to ensure staff compliance with CAP o At least 2 family visitations weekly in cafeteria to ensure compliance with CAP. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program.** **Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • The CNO/Nurse designee will issue

		weekly reports of compliance to the Governing Board at the weekly communication meeting. • Audits are to continue until 100% compliance has been achieved for 90 days continuously. Additional corrective actions needed will be discussed in the weekly Governing Board communication. Results for QAPI will also be reported to the PI committee to ensure compliance with tracking and any further enhancements to the plan of correction. • A compliance rating of 98% is the selected threshold for the weekly audits. If this threshold is not reached, the CAP will be reviewed and/or revised to include new measures to ensure compliance. • When 100% compliance has been achieved for 90 days.. **Individual Responsible:** • CNO/ Nurse Designee **Date Training Completed:** 8/9/2018 **Date Audits completed:** 11/9/2018

Behaviora l Health Agency
Telephone Contact Numbers

Management and Other Resources

Trent Kelly, Execut ive Director	360-236-4852
Shannon Walker, Operations Manager	360-236-2933
Judy Holman, Survey and Investigation Manager	360-236-2962

Introduction

We require that you submit a plan of correction for each deficiency listed on the inspection report form. Your plan of correction must be submitted to DOH within fourteen calendar days of receipt of the list of deficiencies.

You are required to respond to the Inspection Report with Noted Deficiencies by submitting a plan of correction (POC}. Be sure to refer to the deficiency number. If you include exhibits, identify them and refer to them as such in your POC.

Descriptive Content

Your plan of correction must provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and provide information that ensures the intent of the regulation is met.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

Simply stating that a deficiency has been "corrected" is not acceptable. If a deficiency has already been corrected, the plan of correction must include the following:

- How the deficiency was corrected,
- The completion date {date the correction was accomplished),
- How the plan of correciion will prevent possible recurrence of the deficiency.

Completion Dates

The POC must include a completion date that is realistic and coinciding with the amount of time your facility will need to correct the deficiency. Direct care issues must be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies that require bids, remodeling, replac_ement of equipment, etc., may need more time to accomplish correction; the target completion date, however, should be within a reasonable and mutually agreeable time-frame.

Continued Monitoring

Each plan of correction must indicate the appropriate person, either by position or title, who will be responsible for monitoring the correction of the deficiency to prevent recurrence.

Checklist:

- Before submitting your plan of correction, please use the checklist below to prevent delays.
- Have you provided a plan of correction for each deficiency listed?
- Does each plan of correction show a completion date of when the deficiency will be corrected?
- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated what staff position will monitor the correction of each deficiency?
- If you included any attachments, have they been identified with the corresponding deficiency number or identified with the page number to which they are associated?

Your plan of correction will be returned to you for proper completion if not filled out according to these guidelines. Note:

Failure to submit an acceptable plan of correction may result in enforcement action.

Approval of POC

Your submitted POC will be reviewed for adequacy by DOH. If your POC does not adequately address the deficiencies in your inspection report you will be sent a letter detailing why your POC was not accepted.

Questions?

Please review the cited regulation first. If you need clarification, or have questions about deficiencies you must contact the investigator who conducted the onsite investigation, or you may contact the supervisor.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

December 18, 2018

Smokey Point Behavioral Hospital
3955 156th ST NE
Marysville, WA 98271-4831

Subject: Case Number 2018-11858

Dear Ms. Schneider

The Washington State Department of Health conducted a Behavioral Health investigation at Smokey Point Behavioral Hospital, 3955 156th St. NE Marysville, Washington 98271-4831. Your investigation review was conducted on October 10/2018. The Plan of Correction that was submitted was approved on December 18, 2018. No further action is required.

I sincerely appreciate your cooperation and hard work during the investigation process and look forward to working with you again in the future.

Sincerely,

Gina L. Dick, LMHC, CDP, MHP, MAC
Behavioral Health Reviewer
Investigations and Inspections Office
Washington State Department of Health