STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

October 2, 2019

Agency Name: Smokey Point Behavioral Hospital
Address: 3955 156th St NE, Marysville, WA 98271

Dear Mr. Robertson:

This letter contains information regarding the recent investigation at Smokey Point Behavioral Hospital by the Washington State Department of Health. Your state licensing investigation was completed on 10/01/19.

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 me at the following address:

Deborah Duke, RN, BSN
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) 236-2913. I am also available by email at deborah.duke@doh.wa.gov.

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

Sincerely,

Deborah Duke, RN, BSN
Nurse Consultant

Enclosures: DOH Statement of Deficiencies
Plan of Correction Brochure

Behavioral Health Agency Investigation Report

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

Smokey Point Behavioral Health, 3955 156th St NE, Marysville, WA 98271 Agency Name and Address		Christopher D. Burke Administrator
Investigation Inspection Type	09/05/19 – 09/06/19 Investigation Onsite Dates	33894 Investigator Hospital
2019-11805 Case Number	BHA.FS.60874194 License Number	 BHA/RTF 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 investigation.

Deficiency Number and Rule Reference	Observation Findings	Plan of Correction
WAC 246-341-0640(10) Clinical—Additional record content. Each agency licensed by the department to provide any behavioral health service is responsible or an individual's clinical record content. (10) If treatment is court-ordered, a copy of the order.	Based on record review and interview with staff, the facility failed to ensure that a copy of a court order was in a patient's record who was court-ordered to be at the facility for 1 of 8 patients reviewed (Patient #1). Failure to ensure that a copy of a court order is in a patient's record who is court-ordered to be at the facility can result in unauthorized detention of a patient, which is a violation of patient rights. Findings included: 1. Review of the clinical record for Patient #1 showed that on 08/20/19 the hospital petitioned the court for a 90 day	• **The regulation number;** WAC 246-341-0640(10) • **How the deficiency will be corrected:** The ITA and intake departments were re-educated as to the findings on 10/3/2019. Conformed copies of petitions will be placed in the medical record. Within 24 hours of the court conforming any petition or detention. • **Who is responsible for**

	detention of the patient. The record did not contain a copy of the court-order for the 90 day detention. 2. During an interview on 09/06/19, Staff E, Office Staff, stated that there were no loose documents waiting to be filed in patient records.	**making the correction;** The director of PI and Risk is responsible for making the correction. • **When the correction will be completed** 10/17/2019 • **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.** ITA department will review and report out compliance for 30 days of review by ensuring every patient's conformed petition is placed in the medical record. The ITA coordinator at the end of the 30 days will report the number of compliant filed conformed petitions over the total number of petitions submitted to the PI director. If the compliance rating is 98% and if it falls below 98% in the total of the 30 days an additional 30 days will be added to the

		corrective action plan until 98% compliant.
RCW 71.05.330(1): Early release—Notice to court and prosecuting attorney—Petition for hearing. (1) Nothing in this chapter shall prohibit the superintendent or professional person in charge of the hospital or facility in which the person is being involuntarily treated from releasing him or her prior to the expiration of the commitment period when, in the opinion of the superintendent or professional person in charge, the person being involuntarily treated no longer presents a likelihood of serious harm. Whenever the superintendent or professional person in charge of a hospital or facility providing involuntary treatment pursuant to this chapter releases a person prior to the expiration of the period of commitment, the superintendent or professional person in charge shall in writing notify the court which committed the person for treatment.	Based on record review and interview with staff, the facility failed to notify the court which committed a person for treatment when the person was released prior to the expiration of the commitment period, for 1 of 8 patients reviewed (Patient #2). Failure to notify the court which committed a person for treatment when the person is released prior to the expiration of the commitment period, creates a lapse in continuity of care which can result in poor patient outcomes. Findings included: The facility failed to notify the court of a patient's release prior to the expiration date of their involuntary commitment based on the following: a. Review of clinical records for Patients #2 showed that the patient was placed on an order for less restrictive alternative (LRA) on 07/15/19, which was revoked on 08/14/19 for violation of the LRA resulting in his detainment at the hospital. On 08/20/19 the patient was ordered to treatment for the remainder of the original 90 day LRA. The patient was discharged from the hospital on 09/05/19, 38 days prior to the expiration of his court order. Review of Patient #2's record showed no documentation that the hospital notified the court of the patient's release prior to the expiration of the commitment period. b. During an interview on 09/05/19, Staff B, Director of Clinical Services, stated that the facility received an email on 07/11/19 which she believed directed the hospital that they were not required to notify the court when a patient was discharged prior to the expiration of their court ordered	• **The regulation number;** RCW 71.05.330(1) • **How the deficiency will be corrected:** The ITA department was re-educated of the finding, and will ensure that notification happens within 24 business hours (week day). The documentation was in the electronic records of the ITA department and it was confirmed that the court was notified. ITA will ensure the documentation proving notification is in the medical record. HIM department does not process any legal documents and would not have the information requested by surveyors. The ITA department did fail to notify the DCR department of discharges, per our records the notification by VOA and DCR's notification to SPBH, ITA department, and prosecutors to stop notification of discharges. This was clarified with North Sound and the court and notifications began when clarified. The ITA department has created

	treatment. On 09/06/19, Staff B stated that she had miss-read the email and agreed that notification is a requirement.	a document that documents notification of discharge to the courts and DCR. • **Who is responsible for making the correction;** The director of PI and Risk is responsible for making the correction. • **When the correction will be completed** 10/17/2019 • **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.** ITA department reviews with the courts and the VOA on all discharges and is reconciled with the two entities. The implemented document will be filed within 24 business hours (week day) of notification Any identification during reconciliation by any entity, found to be non-compliant will be reviewed by the ITA

		department and PI director to determine if further changes to process's must be implemented.
RCW 71.05.435(1): Discharge of person from treatment entity—Notice to designated crisis responder office. (1) Whenever a person who is the subject of an involuntary commitment order under this chapter is discharged from an evaluation and treatment facility, state hospital, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program providing involuntary treatment services, the entity discharging the person shall provide notice of the person's discharge to the designated crisis responder office responsible for the initial commitment and the designated crisis responder office that serves the county in which the person is expected to reside. The entity discharging the person must also provide these offices with a copy of any less restrictive order or conditional release order entered in conjunction with the discharge of the person, unless the entity discharging the person has entered into a memorandum of understanding obligating another entity to provide these documents. (2) The notice and documents referred to in subsection (1) of this section shall be provided as soon as possible and no later than one business day following the discharge of the person. Notice is not required under this section if the discharge is for the purpose of transferring the person for continued detention and treatment under this chapter at another treatment facility.	Based on record review and interview with staff, the facility failed to notify the designated crisis responder (DCR) office responsible for the initial commitment, and the DCR office serving the county in which the person was expected to reside, whenever a person who was subject to an involuntary commitment order was discharged from the hospital for 3 of 8 patients reviewed (Patients #2, #3 and #5). Failure to notify the designated crisis responder (DCR) office responsible for the initial commitment, and the DCR office serving the county in which a person is expected to reside, whenever a person who was subject to an involuntary commitment order is discharged from the hospital, creates a lapse in continuity of care which can result in poor patient outcomes. Findings included: The facility failed to notify DCR's of patient releases from court ordered treatment as required based on the following: a. Review of clinical records for Patients #2, #3 and #5 showed no documentation notifying the DCR office responsible for the initial commitment, and the DCR office serving the county in which the person was expected to reside, of the patients discharge from the facility. b. During an interview on 09/05/19, Staff B, Director of Clinical Services, stated that North Sound BHO managed all involuntary commitment processes at the facility until they went away on 07/01/19.	• **The regulation number;** RCW 71.05.435(1) • **How the deficiency will be corrected:** The ITA department was re-educated of the finding, and will ensure that notification happens within 24 business hours (week day). The documentation was in the electronic records of the ITA department and it was confirmed that the court was notified. ITA will ensure the documentation proving notification is in the medical record. HIM department does not process any legal documents and would not have the information requested by surveyors. The ITA department did fail to notify the DCR department of discharges, per our records the notification by VOA and DCR's notification to SPBH, ITA department, and prosecutors to stop notification of discharges. This was clarified with North Sound and the court and notifications began when clarified.

		The ITA department has created a document that documents notification of discharge to the courts and DCR. • **Who is responsible for making the correction;** The director of PI and Risk is responsible for making the correction. • **When the correction will be completed** 10/17/2019 • **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.** ITA department reviews with the courts and the VOA on all discharges and is reconciled with the two entities. The implemented document will be filed within 24 business hours (week day) of notification Any identification during reconciliation by any entity, found to be non-compliant will

		be reviewed by the ITA department and PI director to determine if further changes to process's must be implemented. This will be an ongoing process.
WAC 246-341-1126(9)(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: (9) The treatment plan must contain documentation of: (d) A plan for discharge including a plan for follow-up where appropriate.	Based on patient record reviews, the facility failed to ensure treatment plans contained documentation of a plan for discharge including a plan for follow-up where appropriate for 8 of 8 patients reviewed (Patients #1 - #8). Failure to ensure treatment plans contain documentation of a plan for discharge including a plan for follow-up where appropriate can result in inappropriate discharge plans, which can result in patient relapse and poor outcomes. Findings included: Review of clinical records for Patients #1 through #8 showed that the Initial Treatment Plan forms have a Preliminary Discharge Plan section that instructs clinicians to circle Return Home, Return to Placement, or Other. The form does not include a section for follow-up care other than the location the patient is to be discharged to, such as continued care and treatment needs of the patient. The following patients showed that follow-up care was appropriate for their treatment plan as follows: a. Review of the clinical record for Patient #2 showed that the patient was homeless and was detained for violating his less restrictive alternative (LRA) by not attending appointments, not taking all medications as prescribed, taking un-prescribed medications, and making threats to harm his family and himself. The patient's Initial Treatment Plan documents his Preliminary Discharge Plan is to Return to Placement. His treatment plan addresses missing groups, danger to self, danger to others with psychosis, suicidal ideation, substance	• **The regulation number;** WAC 246-341-1126(9)(d) • **How the deficiency will be corrected:** SPBH developed a new "Discharge Planning" treatment plan which addresses follow-up care issues and needs. Therapists, discharge planners, and nurses were in-serviced on this new form and accompanying process beginning October 3, 2019. The new tool will roll-out by October 10, 2019. • **Who is responsible for making the correction;** Director of Clinical Services and Chief Nursing Officer • **When the correction will be completed** 10/17/2019 • **How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be**

	use, nicotine dependence, chronic pain, insomnia, and constipation. The treatment plan does not address the patient's homelessness, attending appointments when discharged, or taking all medications as prescribed when discharged. b. Review of the clinical record for Patient #4 showed that the patient's home situation had been "unstable for a while" due to her grandmother suffering from Alzheimer's, her stepfather being in the hospital dying, and her brother bullying her. The patient's Initial Treatment Plan- Preliminary Discharge Plan is blank. Her treatment plan addresses left arm pain, insomnia, obesity, and danger to self. It does not address the patient's need for a stable living situation. c. Review of the clinical record for Patient #5 showed that the patient came from an adult family home (AFH), but was unable to return or to live with family. The patient had a diagnosis of Schizophrenia and was detained due to "He was not able to articulate a plan to care for himself if he left the hospital and did not have clear insight that he has an infection that would continue to need treatment with antibiotics once discharged. He lacked insight into his physical and mental health needs and is exhibiting poor judgement due to his mental state." The patient made several delusional statements to the DCR about medications and stated to her that he would not take his Risperdal (antipsychotic medication). The patient refused medications throughout his hospital stay, including refusing his antipsychotic medications the day prior to his discharge. The Initial Treatment Plan states that the Preliminary Discharge Plan was to "find placement, shelter". The patient's treatment plan addresses risk for falls, nicotine dependence, obesity, GERD, incontinence, skin breakdown, insomnia, and psychosis. The plan does not address his need for shelter, or his need for continued care when discharged from the hospital including his need to take his prescribed medications.	**measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations.** 16 charts will be audited 5 days a week to ensure that treatment plans include discharge planning, when appropriate, and reported to Performance Improvement department monthly. SPBH will continue to train and educate until 90% compliance is reached for two consecutive months.

WAC 246-341-0620(1)(f) Clinical—Individual service plan. Each agency licensed by the department to provide any behavioral health service is responsible for an individual's service plan as follows: (1) The individual service plan must: (f) Be updated to address applicable changes in identified needs and achievement of goals.	Based on record review, the facility failed to update the individual service plan of a patient when an identified need was changed for 1 of 8 patients reviewed (Patient #4). Failure to update the individual service plan of a patient when an identified need is changed can result in identified patient needs not being addressed, which can result in poor patient outcomes. Findings included: Review of the clinical record for Patient #4 showed that the Master Treatment Plan states that the patient would be discharged to "home". The Inpatient Progress Note dated 08/22/19 states that the patient's mother was considering a move to Texas because "having her go back home is not an option". The treatment plan was not updated to show the anticipated move to Texas.	• **The regulation number;** WAC 246-341-0620(1)(f) • **How the deficiency will be corrected:** Clinical services staff were educated and retrained on including all treatment changes within the treatment plan in order to prevent poor patient outcomes and provide optimal care to patients. • **Who is responsible for making the correction;** Director of Clinical Services • **When the correction will be completed** 10/17/2019 • **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.** 16 charts will be audited 5 days a week to ensure that treatment plans include all changes to the patient throughout the hospital visit, and reported to

		Performance Improvement department monthly. SPBH will continue to train and educate until 90% compliance is reached for two consecutive months.
WAC 246-341-0640(15)(b)(iv) Clinical—Additional record content. Each agency licensed by the department to provide any behavioral health service is responsible for an individual's clinical record content. The clinical record must include: (b) Discharge information for an individual who did not leave without notice, completed within seven working days of the individual's discharge, including: (iv) Current prescribed medication.	Based on record review, the facility failed to document discharge information of current prescribed medications for an individual who did not leave without notice for 1 of 8 patients reviewed (Patient #6). Failure to document discharge information of current prescribed medications for an individual who did not leave without notice can result in a medication error, which can result in patient harm. Findings included: Review of the clinical record for Patient #6 showed that the patient was discharged as planned on 08/10/19. The record showed that the patient was given a prescription for four medications. The discharge plan does not list the current prescribed medications in the Discharge Medications section. The Discharge Medications section on the discharge plan is blank.	• **The regulation number;** WAC 246-341-0640(15)(b)(iv) • **How the deficiency will be corrected:** SPBH has implemented an electronic medical record system, HCS, that provides patients their medication reconciliation and discharge medication list. During this process, patient's sign that their medications have been reviewed with them by nursing staff, as well as, the patient is provided a copy. Nursing and clinical services staff have been educated and retrained on ensuring that patients have information about the current prescribed medications prior to discharging from SPBH. • **Who is responsible for making the correction;** Chief Nursing Officer and Director of Clinical Services • **When the correction will**

		be completed 10/17/2019 • **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.** 16 charts will be audited 5 days a week to ensure that patients have signed for and received a copy of their discharge medication list, and reported to Performance Improvement department monthly. SPBH will continue to train and educate until 90% compliance is reached for two consecutive months.

Behavioral Health Agency
Telephone Contact Numbers

Management and Other Resources

Trent Kelly, Executive Director	360-236-4852
Shannon Walker, Operations Manager	360-236-2933
Jon Kuykendall, Investigation Manager	360-236-2938

Introduction
We require that you submit a plan of correction for each deficiency listed on the investigation 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 Investigation 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 correction 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, replacement 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.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

COPY

October 14, 2019

Facility Name: Smokey Point Behavioral Hospital
Address: 3955 156th St NE, Marysville, WA 98271

Re: Case Number: 2019-11805
License Number: BHA.FS.60874194
Acceptable Plan of Correction
Date of Survey: September 5, 2019 – September 6, 2019

Dear Mr. Robertson:

This letter is to inform you that after careful review of the Plan of Correction (POC) you submitted for the investigation recently conducted at your facility, the Department has determined that the POC is acceptable. You stated in your plan that you will implement corrective actions by the specified timeline. By this, the Department is accepting your Plan of Correction as your confirmation of compliance.

Based on the scope and severity of the deficiencies listed in your statement of deficiency report, the Department will not conduct an unannounced follow-up compliance visit to verify that all deficiencies have been corrected. Any fees that may be enforced based on the results of the investigation will be implemented consistent with WAC 246-341-0365 and WAC 246-337-990

In addition, the Department reserves the right to pursue enforcement action for any repeat and/or uncorrected deficiencies based on applicable statute and rules.

Please feel free to contact me at deborah.duke@doh.wa.gov if you have questions regarding the investigation.

The survey team sincerely appreciates your cooperation and hard work during the investigation.

Sincerely,

Deborah Duke, RN, BSN
Washington State Department of Health
HSQA/Office of Health Systems Oversight