STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

February 5, 2019

Sally Schneider
Smokey Point Behavioral Health Hospital
3955 156th St. NE
Marysville, Washington 98271-4831

Dear Ms. Schneider:

This letter contains information regarding the recent investigation at Smokey Point Behavioral Health Hospital by the Washington State Department of Health. Your state licensing investigation was completed on date January 9, 2019.

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:

Gina L. Dick, LMHC, CDP, MHP, MAC
Department of Health, Office of Health Systems Oversight
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. I am also available by email at Gina.Dick@dshs.wa. gov .

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

Sincerely,

Gina L. Dick, LMHC, CDP, MHP, MAC
Behavior Health Reviewer
Office of Health Systems Oversight
Health Systems Quality Assurance Division
Washington State Department of Health

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

February 5, 2019

Smokey Point Behavioral Hospital: 3955 156th St NE Marysville, WA. 98271-4831 Agency Name and Address		Sally_ Schneider-CEO Administrator
Investigation Inspection Type	December 17, 2018 and January 8-9, 2019 Investigation Onsite Dates	Gina L. Dick, LMHC, CDP, MHP, MAC Investigator
2018-17030 Case Number	60874194 License Number	E&T/MH/SUD 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 investigation.

Deficiency_ Number and Rule Reference	Observation Findings	Plan of Correction
WAC 246-341-0600(1)(a) Receive services without regard to race, creed, national origin, religion, **gender,** sexual orientation, age or disability;	The Washington State Administrative Code is not met as evidenced by: Based on clinical record review December 17, 2018 and clinical record review January 8-9, 2019 and staff interviews January 8-9, 2019 the patient was pressured to attend a women's only group track despite identifying as transgender male. Findings included: Based on clinical record review 12/17/2018 and 1/8-9/2019 1. The clinical record contains nine specific women only group progress notes.	**WAC 246-341-0600(1)(a) Plan of Correction for Each specific deficiency Cited:** • The hospital failed to provide services without regard to gender. **Procedure/process for implementing the plan of correction:** • On 12 February 2019 hospital staff were re-educated on the working with and supporting patients that identify as transgender. Educations included how to identify patients as transgender, reviewing clinical record, preferred pronouns, and clinical documentation to support transgender patients. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • During treatment teams, each patient will be

	2. Based on clinical record review the discharg summary from the transferring hospital identifies the patient as transgender male and the agencies own physical exam note identifies the patient as transgender male. 3. Based on the interview 1/9/2019 at 1149 am with group clinician who indicates she did not know the patient was transgender male at first because it was not indicated on the "board." 4. The clinician stated she did not review the client record or individual service plan prior to documenting his not meeting treatment goals on his service plan or a review to determine if the group was appropriate for the patient.	reviewed to identify their gender, reflected in their medical record, and on unit white boards. • Program directors, Director of Clinical Services, or Director of Nursing will randomly audit at minimum 2 charts per unit and a maximum of 10 charts weekly to ensure compliance and inclusiveness of all patient identification. • The needs of the patient are to be addressed that each patient has a specific treatment plan that is created with input from the patient. **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:** • Program directors, Director of Clinical Services, or Director of Nursing will aggregate and analyze via the created checklist for their reports on the weekly basis. • Non-compliance will be addressed via re-education. • Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard. **Individual Responsible:** Director of Clinical Services **Date Completed:** 2/18/2019

WAC 246-341-0600(l)(c) Be reasonable accommodated in case of sensory or physical disability , limited ability to communicate, limited English proficiency, and **cultural differences;**	The Washington State Administrative Code is not met as evidenced by: Based on clinical record review December 17, 2018 and clinical record review January 8-9, 2019 and staff interviews January 8-9, 2019 the patients cultural differences were not recognized or accommodated as evidenced by continued documentation of women only group notes despite identifying as transgender male. Findings included: During clinical record review on 12/17/2018 and 1/8-9/2019; 1. Group notes written on 9/26/2018 while patient was admitted did not address the appropriateness of having him attend a women's only track. 2. Group notes indicate the patient had not met his treatment goals because he did not attend the groups. Despite the clinician indicating the patient's agreement to take the group literature, read, and complete the information. 3. Based on interview with group clinician 1/9/2019 at 1149 am, the clinician did not follow up with the patient about completion of literature, or why he did not attend group.	WAC 246-341-0600(l)(c) **Plan of Correction for Each specific deficiency Cited:** • The hospital failed to provide services without regard to cultural differences. **Procedure/process for implementing the plan of correction:** • On 12 February 2019 hospital staff were re-educated on the working with and supporting patients that have cultural differences. Education included how to identifying cultural differences, reviewing clinical record, how to support and incorporate patient's cultural differences into their care, and clinical documentation to support cultural competence. • The needs of the patient are to be addressed that each patient has a specific treatment plan that is created with input from the patient. • The needs of the patient are to be addressed that each patient has a specific treatment plan that is created with input from the patient. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** During treatment teams, each patient will be reviewed to identify cultural differences, reflected in their medical record, and treatment plans. • Program directors, Director of Clinical Services, or Director of Nursing will randomly audit 2 charts per unit and a maximum of 10 charts weekly weekly to ensure compliance and inclusiveness of all patient identification. **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:** • Program directors, Director of Clinical Services, or Director of Nursing will aggregate and analyze

		via the created checklist for their reports on the weekly basis. • Non-compliance will be addressed via re-education. • Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard. **Individual Responsible:** Director of Clinical Services **Date Completed:** 2/18/2019

Violation of WAC 246- 341-0640 (17) The clinical record must include:(17) Progress notes must include the date, time, duration, participant's name, response to interventions, and a brief summary of the session and the name and credential of the staff member who provided it:	The Washington State Administrative Code is not met as evidenced by: Based on clinical record review December 17, 2018 and clinical record review January 8-9, 2019 the clinical record did not contain group progress notes with accurate documentation of services provided and the patient's response to interventions. Findings included: Review of clinical record December 17, 2018 at 10:25am and January 8, 2019 at 8:00am- 1. The patient a transgender male was admitted to the facility 9/25/2018 at 2:43pm. 2. Three group notes for this patient were written prior to the patient's admission to the facility. Patient admitted to facility at 2:43pm on 9/25/2018. Three women's only group notes contained in the clinical record written by the clinician were written at 3:00pm 9/25/2018 for a 10:30 am women's only group, four hours prior to admission. 11:30 am women's group, three hours prior to admission. As well as a 1:30 pm, women's only group note, one hour prior to admission to the facility. 3. Clinical record review demonstrate women' s group notes were contained in the record despite patient identifying as transgender male. 4. Group progress notes written indicate patient did not meet treatment goals due to not	**WAC 246- 341-0640 (17) Plan of Correction for Each specific deficiency Cited:** • The hospital failed to complete group progress notes with accuracy. **Procedure/process for implementing the plan of correction:** • On 12 February 2019 hospital staff were re-educated on completion of group progress notes. Education included date, time, duration, participant's name, response to interventions, and a brief summary of the session and the name and credential of the staff member who provided it. • The needs of the patient are to be addressed that each patient has a specific treatment plan that is created with input from the patient. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Program directors, Director of Clinical Services, or Director of Nursing will randomly audit 2 charts per unit and a maximum of 10 charts weekly weekly to ensure compliance and inclusiveness of all elements of documentation. **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:** • Program directors, Director of Clinical Services, or Director of Nursing will aggregate and analyze via the created checklist for their reports on the weekly basis. • Non-compliance will be addressed via re-education. • Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard. **Individual Responsible:** Director of Clinical Services **Date Completed:** 2/18/2019

	contains group notes that document the patient to have not met treatment goals. 7. For all attended groups the clinical record documents patient met treatment goals, despite documenting the client did not participate, was withdrawn and nonverbal during group. 8. The clinician documented the patient's response to six women's groups without having seen the patient and without having completed a review of the clinical record including individual service plan.	

Behavioral Health Agency
Telephone Contact Numbers

Management and Other Resources

Trent Kelly, Executive 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 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.

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

March 14, 2019

Sally Schneider - CEO
Smokey Point Behavioral Health Hospital
3955 156th St. NE
Marysville, Washington 98271-4831

Subject: 2018-17030

Dear Ms. Schneider:

The Washington State Department of Health conducted a Behavioral Health investigation at Smokey Point Behavioral Health Hospital3955 156th St. NE Marysville, Washington 98271. Your investigation review was conducted on December 17, 2018 and January 8-9, 2019. The Plan of Correction that was submitted was approved on February 19, 2019. 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, MAC
Behavioral Health Reviewer
Investigations and Inspections Office
Washington State Department of Health