State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013220	A. BUILDING: _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC), 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation. On site dates: 03/07/23, 03/30/23, and 04/10/23 Case number: 2023-2563 Intake number: 129088 This investigation was conducted by Investigator #1 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by 05/01/23. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or	L1065		

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L1065	Continued From page 1 retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Item #1 - Comprehensive Treatment Plan Developed Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure the development and implementation of an individualized comprehensive treatment plan for all patients that included identified treatment problems, long-term and short-term goals, and staff interventions, as demonstrated by 3 of 3 records reviewed (Patient #1501, #1502, and #1503). Failure to develop an individualized comprehensive treatment plan of care can result in inappropriate, inconsistent, or delayed treatment, which may lead to potential patient harm, injury and/or death. Findings included:	L1065		

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L1065	Continued From page 2 1. Document review of the hospital's policy and procedure titled, "Program Overview/Scope of Care - Inpatient," policy number 13083821, effective 02/23, showed the following: a. The Inpatient Program provides intensive treatment for patients suffering from substance use/co-occurring, acute psychiatric disorders, cognitive impairment, and co-occurring disorders. b. The multidisciplinary treatment team provides each patient entering the program with a comprehensive assessment and creates an individually tailored plan for treatment. c. The provision of treatment requires that we recognize, acknowledge, plan, and provide a program for the acuity of patients, for their safety, and their appropriate length of stay. d. The multidisciplinary process of assessment, planning, and intervention provides the framework for individualized treatment plans with patients and/or families and/or significant others. Document review of the hospital's policy and procedure titled, "Treatment Planning - Philosophy and Purpose," policy number 11887747, effective 07/22, showed the following: a. The hospital believes that the Interdisciplinary Treatment Plan can be an effective therapeutic tool, which is productive and helpful to staff as well as patients. b. The success of the plan depends upon the following: i. The assurance that every patient will have an individualized plan specific to his/her assessed	L1065		

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L1065	Continued From page 3	L1065		

needs and that the patient's attending physician will direct and participate in all phases of the treatment planning process.

ii. The diagnostic and therapeutic services prescribed by the attending clinical staff.

iii. The clinical ability of the staff to evaluate the plan's effectiveness.

c. The Master Treatment Plan (MTP) for Inpatient (IP) must be initiated during the first individual session following the assessment. The MTP must be completed within 72 hours.

d. Procedures for the MTP:

i. The patient's needs are identified from the information obtained on the initial assessments, including Comprehensive Psychiatric Evaluation, History and Physical, Screening Assessment, Psychosocial Assessment, Initial Nursing Assessment, and Activity Therapy Assessment.

ii. Care planning includes the development of measurable treatment goals. Care, treatment, and services will be planned, which include patient objectives, staff interventions, services and treatments necessary to assist the patient in meeting the identified care plan goals.

e. The MTP plan of care, treatment, and services includes, but may not be limited to:

i. Defined problems and evidence of those problems.

ii. Measurable goals based on the assessed needs, strengths, and the patient's limitations.

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L1065	Continued From page 4 iii. Interventions are specifically sufficient to evaluate the patients' progress, expressed in behavioral terms that specify measurable progress. iv. Individual service plan includes the assignment of work to an individual or discipline. v. The frequency of care, treatment, and services. vi. Possible barriers to care, treatment, services, or reaching goals. vii. A plan for discharge, including a plan for follow-up, where appropriate. Patient #1501 2. Patient #1501 was a 38-year-old female admitted voluntarily on 02/14/23 for mood dysregulation and psychosis. The Patient was responding to internal stimuli and increased agitation. Her psychiatric diagnosis was Schizoaffective Disorder, Bipolar Type. She had a medical diagnosis of Hypertension (high blood pressure). Upon admission, Patient #1501 exhibited symptoms of physical aggression and violence. Review of the medical record showed the following: a. On the History and Physical dated 02/15/23, the medical provider documented that the Patient presented with elevated blood pressure (HTN) and prescribed a daily medication (amlodipine) to treat the disorder. In addition, the medical provider noted that the Patient's blood pressure would be monitored, and the medication would be adjusted as needed. The Patient was also prescribed nicotine gum for smoking cessation.	L1065		

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L1065	Continued From page 5 b. On the Comprehensive Psychiatric Evaluation dated 02/15/23, the psychiatric provider documented that the Patient had discontinued her medications in June of 2022. At the time of the assessment, the Patient had increased aggression, anxiety, and paranoia. She refused to take any scheduled psychotropic medications and was unwilling to engage in treatment or aftercare planning. The Patient requested to leave the hospital, and the psychiatric provider contacted the Designated Crisis Responder (DCR) to assess the patient for safety and the capacity for voluntary treatment. c. On the Psychosocial Assessment dated 02/19/23, the clinical staff documented that Patient #1501 had High Risk issues that required treatment planning, including Grave Disability, treatment noncompliance, and aggressive, physically violent behavior. d. The Investigator's review of the Patient's MTP initiated 02/15/23, showed the following: i. On the Problem Statement/Reason for admission, staff documented that the Patient was a direct admit from Peace Health Hospital and was responding to internal stimuli. The psychiatric diagnosis was Schizoaffective Disorder and the medical diagnosis was Hypertension and Tobacco Use Disorder. ii. On the MTP, staff failed to document the Patient's defined psychiatric problem(s), or evidence of these problems, which would determine the course of treatment. iii. Staff identified the Long-Term Goal for Treatment (in the patient's words) to stabilize on a medication and be medication compliant,	L1065		

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L1065	Continued From page 6	L1065		

however the MTP does not identify a patient-specific problem related to the goal.

iv. Staff failed to initiate a Short-Term Goal for the Patient until 02/26/23, when staff documented that the Patient will report improvement of symptoms of psychosis.

v. Without a specific psychiatric problem identified, or individualized Long-Term or Short-Term goals clearly documented, staff checked several boxes for multidisciplinary interventions to be initiated, however the interventions were not specifically tied to an identified problem.

Patient #1502

3. Patient #1502 was a 58-year-old male admitted voluntarily on 02/22/23 for symptoms of worsening mood dysregulation and psychosis. Prior to admission, the Patient armed himself with a gun and aimed it at his neighbor's door. The Patient reported taking his prescribed medications, but only for the last few days prior to admission. The Patient's family is concerned that he will hurt someone. The Patient's psychiatric diagnosis was Bipolar Disorder (most recent episode mixed severe with psychosis) and Anxiety Disorder. Review of the medical record showed the following:

a. On the History and Physical dated 02/23/23, the medical provider documented that the Patient would be prescribed nicotine gum for smoking cessation.

b. On the Comprehensive Psychiatric Evaluation dated 02/23/23, the psychiatric provider documented that the Patient presented as

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L1065	Continued From page 7	L1065		

depressed, anxious, and his mood was labile. The Patient was willing to participate in treatment, however the psychiatric provider documented that the Patient exhibited limited insight and impulsive behavior.

c. On the Screening Assessment dated 02/22/23, staff documented that the Patient rated his depression at 5 out of 10, and anxiety at 8 out of 10. The Patient had lost his wife to cancer 6 years ago and was currently caring for his father-in-law. The Patient reported to staff that he had difficulty sleeping and a decrease in appetite. It was reported that the Patient exhibited delusional/paranoid behaviors. Intake staff documented on the High-Risk Form that the Patient's presenting problem was an inability to self-regulate and mania.

d. The Investigator's review of the Patient's MTP initiated on 02/25/23, showed the following:

i. On the Problem Statement/Reason for admission, staff documented that the Patient was a direct admit from Southwest Medical Center. The Patient reported that his family is scared he will hurt someone after he aimed an unloaded gun at the neighbor's door and cocked the trigger. The psychiatric diagnosis was Bipolar Disorder and Anxiety Disorder, and the medical diagnosis was Sleep Apnea and Tobacco Use Disorder.

ii. On the MTP, staff failed to document the Patient's defined psychiatric problem(s), or evidence of these problems, which would determine the course of treatment

iii. Staff failed to identify any Long-Term or Short-Term Goals for Patient #1502.

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L1065	Continued From page 8	L1065		

iv. Without a specific psychiatric problem identified, or Long-Term or Short-Term goals documented, staff checked several boxes for multidisciplinary interventions to be initiated by the psychiatric provider and nursing staff, however the interventions were not specifically tied to an identified problem.

v. On 02/26/23, staff initiated a Mental Health Treatment Plan, identified as Problem #1. Staff documented the Problem Statement as follows: Direct admit from hospital. Family reports decline in functioning. The Long-Term Goal in the patient's words was "I want people to understand my mental health care." Without a specific psychiatric problem identified, or individualized Long-Term goals documented, staff checked several boxes for multidisciplinary Short-Term Goals, however they were not specifically tied to an identified problem.

vi. On 02/22/23, staff initiated a Medical and Pain Treatment Plan for the Patient's active medical condition, Sleep Apnea. The Patient's Long-Term goal is "to function properly." For the Short-Term Goals, staff checked several boxes for multidisciplinary Short-Term Goals, however they were not individualized to the identified problem. Staff interventions failed to address the individualized problem identified (sleep apnea). The following interventions were "checked," however did not relate to sleep apnea: non-pharmacological pain interventions, assess and document pain characteristics and nursing staff will provide medication for pain management.

Patient #1503

4. Patient #1503 was a 61-year-old male admitted

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L1065	Continued From page 9	L1065		

involuntarily on 03/02/23 for symptoms of disorganized psychosis and agitation. The Patient was taken to the emergency department from the group home where he lived due to worsening psychosis stating that he was sniper there and the redness on his right elbow is from getting down in sniper position. Prior to admission, the Patient was aggressive towards staff in the emergency department. The Patient presented as gravely disabled and refused to engage in treatment or take medications. The Patient's psychiatric diagnosis was Psychosis, unspecified. Review of the medical record showed the following:

a. On the Comprehensive Psychiatric Evaluation dated 03/03/23, the psychiatric provider documented that the Patient presented as gravelly disabled and refused to engage in treatment or take medications. The Patient denied any suicidal thoughts or behaviors. The provider documented concerns the patient's ability to sustain medication compliance outside of inpatient setting. The provider also noted the Patient's recent aggressive behavior towards hospital staff in the emergency department prior to admission.

b. On the Midlevel Inpatient Progress Note dated 03/04/23, the medical provider documented that the Patient reported he was urinating frequently. The provider ordered a urine analysis and urine culture, documented to continue to monitor the symptoms and lab results. The medical provider initiated an order for nicotine gum to treat Tobacco Use Disorder and ordered the staff to provide cessation counseling throughout the Patient's admission.

c. On the Midlevel Inpatient Progress Note dated

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L1065	Continued From page 10	L1065		

03/10/23, the medical provider documented that staff observed that the Patient's right hand was swollen. The Patient refused a physical examination from the provider. An order for an X-ray was initiated. On 03/09/23 the Patient complained of a sore throat, and the provider prescribed throat lozenges, documenting to continue to monitor.

d. The Investigator's review of the Patient's MTP initiated on 03/03/23, showed the following:

i. On the Problem Statement/Reason for admission, staff documented that the Patient was a direct admit and was responding to internal stimuli (RIS) and speaking in word salad (confused, unintelligible mixture of random words and phrases The psychiatric diagnosis was Psychosis, unspecified, and the medical diagnosis was Urinary Frequency and Tobacco Use Disorder.

ii. On the MTP, staff failed to document the Patient's defined psychiatric problem(s), or evidence of these specific problems, which would determine the course of treatment.

iii. Staff documented that the Patient's Long-Term Goal was to stay stable and be medication compliant and to rate symptoms of depression no more than 3 out of 10 for 2 consecutive days prior to discharge. For the Short-Term Goals for Patient #1503, staff documented that the Patient will "report any suicidal thoughts or urges to staff before acting on them and feel better emotionally". Review of the Patient's admission assessments found that staff documented a low risk for suicide or suicide behaviors and the Long-Term and Short-Term Goals identified for the Patient are incongruent with the

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L1065	Continued From page 11 assessments. iv. Without a specific psychiatric problem identified, or patient specific, individualized Long-Term or Short-Term goals, staff checked several boxes for multidisciplinary interventions to be initiated by the psychiatric provider and nursing staff, however the interventions were not patient specific, or relevant to an identified problem. v. On 03/02/23, staff initiated a Medical and Pain Treatment Plan for the Patient, however staff failed to document the medical condition to be treated. This was left blank. Additionally, staff failed to document any Long-Term Goals for the Patient, or any Long-Term Goals for discharge. For the Short-Term Goals, staff checked one box: Patient will verbalize understanding of disease process, prognosis, and potential complications related to their current prescribed medications, including the importance of adhering to medications and treatment recommendations by discharge. vi. Though the Patient had denied pain during his admission assessments, had no documented requests for pain medications, and no identified medical comorbid problems requiring pain management, staff initiated Short-Term Pain Goals on 03/02/23: Patient will verbalize a decrease in pain rating on a 0-10 scale within 1 hour of receiving pain medication and/or use non-pharmacological pain interventions including cold, heat, repositioning, diversional activity, relaxation, stretching, low impact exercise, and yoga. vii. Without a specific medical problem identified, or individualized Long-Term or Short-Term goals	L1065		

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L1065	Continued From page 12	L1065		

clearly documented, staff checked several boxes for multidisciplinary interventions to be initiated, however the interventions were not individualized or specifically tied to an identified problem.

5. On 03/30/23 at 3:15 PM, during an interview with Investigator #1, the Director of Quality, Risk and Compliance (Staff #1501) and the Director of Clinical Services (Staff #1506) verified that the treatment plans for Patients #1501, #1502, and #1503 did not have clearly identified psychiatric or medical problems, relevant goals, or individualized interventions. Staff #1506 stated that staff often documents problems to be treated in the Initial Psychiatric Evaluation or in the History and Physical Evaluation. Staff #1501 stated that patients had been unable or unwilling to participate in their treatment, so the treatment team was unable to develop treatment plans. Staff #1501 reported that the hospital had recently changed ownership, and the new company initiated different treatment forms. Staff #1506 stated that the treatment documentation was incomplete or missing due to recent staffing shortages.

Item #2 -Weekly Updates to Treatment Plan

Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff updated the patient's treatment plan weekly, as demonstrated by 3 of 3 records reviewed (Patient #1501, #1502, and #1503).

Failure to update a patient's treatment care plan can result in inappropriate, inconsistent, or delayed treatment, which may lead to patient harm and lack of appropriate treatment for a

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L1065	Continued From page 13	L1065		

behavioral or medical condition.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Program Overview/Scope of Care - Inpatient," policy number 13083821, effective 02/23, showed the following:

a. The multidisciplinary treatment team provides each patient entering the program with a comprehensive assessment and creates an individually tailored plan for treatment. The treatment plan may include medications, intensive individual therapy, group therapy, family therapy, and educational skill building activities.

b. The treatment team will evaluate the patient's level of participation, and provide alternative treatments if needed. Treatment plan updates will address lack of participation and interventions will be developed to encourage active patient participation in treatment.

c. The multidisciplinary process of assessment, planning, and intervention provides the framework for individualized treatment plans with patients and/or families and/or significant others.

Document review of the hospital's policy and procedure titled, "Treatment Planning - Philosophy and Purpose," policy number 11887747, effective 07/22, showed the following:

a. The Master Treatment Plan (MTP) for Inpatient (IP) must be initiated during the first individual session following the assessment. The MTP must be completed within 72 hours.

b. The Treatment Plan will be updated at least

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L1065	Continued From page 14	L1065		

weekly in IP.

c. The Treatment Plan review/update that evaluates the patient's response to goals and interventions will be revised based on changes in the patient's condition, problems, needs, and responses to care, treatment, and services. If there is no appreciable change in the patient's condition, goal and objectives will be reevaluated and revised on a weekly basis at a minimum for inpatient.

Patient #1501

2. Patient #1501 was a 38-year-old female admitted voluntarily on 02/14/23 for mood dysregulation and psychosis. The Patient was responding to internal stimuli and increased agitation. Her psychiatric diagnosis was Schizoaffective Disorder, Bipolar Type. She had a medical diagnosis of Hypertension (high blood pressure). Review of the medical record showed the following:

a. On 03/07/23, the Investigator reviewed the medical record for Patient #1501. On the MTP dated 02/15/23, staff failed to document the Patient's defined psychiatric problem(s), or evidence of these problems, which would determine the course of treatment. At the time of the review, the medical record did not contain a treatment update, which is done weekly (due 02/22/23) after the initiation of the MTP.

b. On 04/10/23, the hospital provided additional medical record documents to the Investigator for Patient #1501. On the Treatment Plan Addendum dated 03/01/23, staff documented the Patient's progress towards Goal #1a (auditory hallucinations) and Goal #1g (psychosis). The

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	013220	A. BUILDING: _____ B. WING _____	C 04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINIER SPRINGS	2805 NE 129TH ST VANCOUVER, WA 98686

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L1065	Continued From page 15	L1065		

addendum was signed on 03/01/23 by an RN and Clinical Therapist and signed electronically by the psychiatrist on 03/22/23. The addendum also updated the Patient's progress for the same goals on 03/08/23, however there is no staff signature dated 03/08/23.

c. Review of the documents provided on 03/07/23 and 04/10/23 found that staff failed to document the patient's status/progress towards the Patient's identified medical problem, Hypertension (high blood pressure).

Patient #1502

3. Patient #1502 was a 58-year-old male admitted voluntarily on 02/22/23 for symptoms of worsening mood dysregulation and psychosis. The Patient's psychiatric diagnosis was Bipolar Disorder (most recent episode mixed severe with psychosis) and Anxiety Disorder. The Patient was discharged on 03/06/23. Review of the medical record showed the following:

a. The Patient's MTP initiated on 02/25/23, found that staff failed to document the Patient's defined psychiatric problem(s), or evidence of these problems, which would determine the course of treatment.

b. At the time of the Investigator's review on 03/30/23, the medical record did not contain a treatment update, which is done weekly (due 03/03/23) after the initiation of the MTP.

Patient #1503

4. Patient #1503 was a 61-year-old male admitted involuntarily on 03/02/23 for symptoms of disorganized psychosis and agitation. The Patient

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L1065	Continued From page 16	L1065		

presented as gravely disabled and refused to engage in treatment or take medications. The Patient's psychiatric diagnosis was Psychosis, unspecified and his medical diagnosis was Frequent Urination. Review of the medical record showed the following:

a. On the MTP initiated 03/03/23, staff failed to document the Patient's defined psychiatric problem(s) or medical problem(s), or include evidence of these specific problems, which would determine the course of treatment.

b. At the time of the Investigator's review on 03/30/23, the medical record did not contain treatment updates, which is done weekly (due 03/10/23, 03/17/23, and 03/24/23) after the initiation of the MTP.

5. On 03/30/23 at 12:15 PM, during an interview with Investigator #1, the Director of Quality, Risk and Compliance (Staff #1501) and the Director of Clinical Services (Staff #1506) verified that Patients #1501, #1502, and #1503 did not have the required weekly treatment plan updates. Staff #1501 stated that patients had been actively psychotic or delusional and unable or unwilling to participate in their treatment. The Investigator asked Staff #1501 and #1506 how the treatment team measures the patient's progress or status. Staff #1506 stated that typically staff would document that in the progress notes, not in the treatment documents.

6. On 03/30/23 at 1:55 PM, during an interview with Investigator #1, the Medical Director (Staff #1507) verified that the medical records did not consistently include weekly treatment plan updates. Staff #1507 stated that Patient #1503 had been resistant to treatment interventions. He

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L1065	Continued From page 17	L1065		

reported that staff had made several attempts to engage the Patient to participate in treatment planning. Staff #1507 noted that he was unsure if this was documented in the treatment plan.

Item #3 -Treatment Plan Updates After Adverse Incidents

Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff updated and modified the patient's treatment plans after adverse incidents, including incidents of sexually inappropriate behavior, sexual assault, and/or sexual aggression, as demonstrated by 3 of 3 records reviewed (Patient #1501, #1502, and #1503).

Failure to update and modify a patient's treatment care plan after adverse incidents places the patients at risk for inappropriate, inconsistent, or delayed treatment, or patient harm.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Sexual Acting Out (SAO)," policy number 11564685, effective 04/22, showed the following:

a. Sexual behavior involving patients is prohibited. All allegations or observations of sexual behavior between patients will be investigated. The hospital will consider any allegation of sexual activity among patients as Sexually Acting Out (SAO) and nonconsensual.

b. For reported or observed sexual behavior, staff will communicate the incident in shift report, and

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L1065	Continued From page 18	L1065		

update the Treatment Plan for each patient.

c. The Director of Clinical Services will guide the multidisciplinary team to assess each patient's status and recommend further treatment interventions, which may include:

i. Short-Term Behavioral Goal for prevention of further incidents

ii. Short-Term Goal to help process the impact of trauma to individuals.

Document review of the hospital's attachment to Sexual Acting Out Policy titled, "Response and Notification Checklist for: Alleged/Actual Patient to Patient Sexual Incident - Inpatient," no policy number, edited 04/15/22, included the following:

a. Instructions: Complete all Section 1 and explain all NO responses in space provided.

b. Section 1 - Secondary Actions: Communicate incident at shift report. Update Treatment Plan for each patient.

2. On 02/27/23 at approximately 6:00 PM, Patient Care Assistant (PCA) staff heard moaning inside a patient's room. The PCA entered the room of Patient #1501, and found Patient #1501 laying on the bed naked, with a male patient (Patient #1502) standing above her, zipping up his pants. Patient #1501 was a 38-year-old female admitted voluntarily on 02/14/23 for mood dysregulation and psychosis. Patient #1502 was a 58-year-old male admitted voluntarily on 02/22/23 for symptoms of worsening mood dysregulation and psychosis.

3. Immediately after the incident, hospital staff

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L1065	Continued From page 19	L1065		

implemented the incident response protocol and documented their process on the Response and Notification Checklist for Alleged/Actual Patient to Patient Sexual Incident - Inpatient. Review of the Checklist found that staff left the following section blank: Secondary Actions: Communicate incident at shift report. Additionally, staff failed to document that the treatment plan would bed updated, leaving that section blank.

4. Review of Patient #1501 and #1502's medical records found that staff failed to document the sexual incident in either of the patient's treatment plans. Staff failed to add the problem to the MTP or initiate an individual treatment plan to specifically address the sexually acting out behavior or include goals and appropriate interventions to prevent further incidents and address experienced trauma.

Patient #1503

5. Patient #1503 was a 61-year-old male admitted involuntarily on 03/02/23 for symptoms of disorganized psychosis and agitation. The Patient presented as gravely disabled and refused to engage in treatment or take medications. The Patient's psychiatric diagnosis was Psychosis, unspecified and his medical diagnosis was Frequent Urination. Review of the medical record showed the following:

a. Review of the Daily Nursing Assessments found that nursing staff frequently documented Patient #1503's inappropriate sexual behaviors and sexual aggression (03/17/23, 03/23/23, 03/24/23, 03/26/23, and 03/28/23).

b. Review of the Daily Inpatient Progress Notes found that the psychiatric providers frequently

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L1065	Continued From page 20	L1065		

documented Patient #1503's inappropriate sexual behaviors, including frequent masturbation, and sexual aggression (03/11/23, 03/12/23, 03/14/23, 03/19/23, and 03/27/23).

c. On 03/17/23 a female patient on the same unit as Patient #1503 reported that he stated to them that "they were hot and they wished they could go to their room."

d. Immediately after the reported incident, hospital staff implemented the incident response protocol and documented their process on the Response and Notification Checklist for Alleged/Actual Patient to Patient Sexual Incident - Inpatient. Review of the Checklist found that staff documented in Section 1 Secondary Actions (Secondary Actions: Communicate incident at shift report. Update Treatment Plan for each patient) that the incident was reported, and the treatment plan was updated.

e. On that same day, nursing staff documented that Patient #1503 became verbally aggressive with a male nurse after he thought that the male nurse was standing too close to the female nurse. After the two SAO incidents on 03/17/23, Patient #1503 was placed on SAO precautions.

6. Review of #1503's medical records found that staff failed to document the sexual incident or increasing sexually inappropriate behavior (SAO) in the patient's treatment plan. Staff did not add the problem to the MTP or initiate an individual treatment plan to specifically address the sexually acting out behaviors or include goals and appropriate interventions to prevent further incidents.

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L1065	Continued From page 21 7. On 03/30/23 at 12:30 PM, during an interview with Investigator #1, the Director of Quality, Risk and Compliance (Staff #1501) and the Director of Clinical Services (Staff #1506) verified that the treatment plans for Patient's #1501, #1502, and #1503 did not have updates or behavioral plans related to the SAO behaviors. Staff #1501 stated that if the patients have engaged in sexually inappropriate behaviors or sexually acting out, then there should be a behavioral plan. Staff #1506 stated that often it depends on how helpful initiating a behavioral plan would be. She reported that for example, Patient #1503, had been refusing to participate in treatment, so having a treatment plan/behavioral plan for SAO behaviors wouldn't be helpful because he was not participating in anything.	L1065		

PLAN OF CORRECTION
Rec'd 06.14.23
Approved 06.20.23
Mary Newmon, RN
DOH

Rainier Springs

Plan of Correction for
State Investigation
(Case #2023-2563)
Exit 04/10/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L1065 Item 1: comprehensive multi-disciplinary treatment plans	Action plan: All clinical services staff will receive training regarding ensuring that the treatment plans are completed within the standards. The training will be completed quarterly by DCS. Training was provided by Anthony Delorenzo, who is the corporate Director of Clinical Services and an LCSW. Disciplines being taught: Motivational interviewing, golden-thread documentation quality, clear connections between high-risk symptoms and what level of care is required to address the risk. This training was then followed up by individual meetings with each staff person and the DCS, as well as continued conversations during team meetings. The difference between this training and those in the past is specificity in focusing on content of problem statement, goals, and high-risk symptoms. We are utilizing our auditing measures to guide our training, rather than relying only on our corporate new employee training or peer training. Another difference is that this is followed up by one-on-one training which can focus on the strengths and deficiencies of staff. Determining competence will come from monthly audits - each therapist will have random charts audited each month and these will be utilized to provide corrective action and/or ensure competence. Additional measures besides training: • Systems changes to procedures and operations which will allow for more individualized time with patients. These changes include:	DCS	6/1/23	QAPI: DCS will ensure that all clinical services employees are trained on the components of the treatment plan by 6/1/23. 10 charts will be audited every month and reported on in the monthly quality committee and quarterly in governing board with a goal of 90% and above for the next 4 months to ensure that the initial treatment plan is completed within 72 hours and any updated treatment plans are completed within 7 days for each stay longer than 7 days. The audit will also ensure that all problem areas that are being treated are documented on the treatment plan. The audits allow the director to see quality of content regarding pt goals, discharge planning, and quality of the golden thread. This information will be used to provide weekly update for each therapist showing their strengths and deficiencies. Weekly reports will be operational by the end of July. Information that is also reviewed during the audits are: • Initial contact made to family within 24 hours and family

	○ Going to a more caseload-focused system for therapists. Increases accountability and organization of tasks for therapist ○ Changing our trackers to be more specific so therapists have more easily accessible information about what paperwork is still needed. This will allow for the leadership to step in and help when we are down staff. ○ Implementation of Inpatient Coordinator whose sole purpose will be compliance measures and ensuring the team has what it needs to do quality work. This position will be operational June 5th, 2023 ○ Hiring more staff - we need more staff on each unit. Hiring issues and staffing shortages have created a lot of barriers to documentation Disciplines that are being trained include nursing, expressive arts therapy, clinical therapy, and medical and psychiatric providers to ensure that treatment plans are reviewed with patients in accordance with policy and that the treatment goals pertain to the problem areas being treated while inpatient. All treatment plans will be reviewed every 7 days while the patient is still inpatient 7 days or more days.			session scheduling form present identifying family session planning. • Therapist contacts referral source and/or outpatient provider within 24 hours of admission. • Safety plan is completed with no blanks and address all high-risk items and access to means of identified in psychosocial assessment and treatment plan. • Discharge Plan is completed in full and includes the next provider of care. • 2 psychotherapy notes and 2 rec therapy notes per day with individualized patient response to group or alternative treatment intervention. • Weekly progress note completed that describes progress related to treatment goals (can be imbedded into a therapy note or in separate progress note). • Discharge Planning Progress Note is filled out completely and addresses all areas of DC planning and safety planning. • Anticipated necessary steps for discharge to occur is documented in an individualized matter on treatment plan. • Specific community resources/support systems for utilization in discharge planning outline on page 10 of

				psychosocial (ex. housing, financial aid, aftercare treatment) are individualized to the patient and not generic or same from patient to patient. • Specific community resources/support systems for utilization in discharge planning outline on page 10 of psychosocial (ex. housing, financial aid, aftercare treatment) are individualized to the patient and not generic or same from patient to patient. • Specific social work/therapist role in treatment and discharge planning is outlined on page 10 of psychosocial (which should then be included in treatment plan) and individualized to the patient. • Substantiated diagnosis from CPE listed on the treatment plan. • Treatment plan will have patient specific long term and short-term goals on each problem sheet. • Specific intervention on the treatment plan to address nonparticipation which would be 3 days or 12 consecutive groups. • Treatment Plan has short term goals that address all high-risk issues. • Treatment plan completed and included signatures, dates, times, and all high-risk issues

				mentioned on all assessments are addressed with short term measurable goals and interventions - within 72 hours. • Treatment plan update completed every 7 days from admission and includes signatures, dates, times, and with all original goals from problem sheets updated including co-morbid issues. • CD Indicator Only: 1 Clean Group note in the medical record.
	Action plan: Inpatient Coordinator is a position that has been created within the hospital to ensure continued improvement of compliance and quality of service at the hospital. This position will provide weekly audits of current patients, assign tasks to therapists, and increase accountability of quality documentation.	Inpatient Coordinator	6/1/23	QAPI: The inpatient coordinator position will begin on 5/8/23 and the DCS will train the inpatient coordinator on how to complete chart audits to ensure that the treatment plans are completed in accordance with the standard. Daily assignments email will track the progress of this action. 10 charts will be audited every month and reported on in the monthly quality committee and quarterly in governing board with a goal of 90% and above for the next 4 months.
L1065 – Item #2 – Weekly Treatment Plan Updates	Action Plan: Accountability measures for weekly treatment plans will be increased by editing the documentation tracking system for IP clinical staff. Disciplines that are being trained include nursing, expressive arts therapy, clinical therapy, and medical and psychiatric providers to ensure that treatment plans are reviewed with patients in accordance with policy and that the treatment	DCS	6/5/23	The IP Clinical Coordinator will do daily checks of the documentation tracker and create weekly reports identifying deficiencies for staff with their documentation. This will include weekly treatment plan updates. The goal is for all therapists to be at least 80% benchmark for documentation weekly. Staff will be put on corrective action for

	goals pertain to the problem areas being treated while inpatient. All treatment plans will be reviewed every 7 days while the patient is still inpatient 7 days or more days.			failing to meet the benchmark for 2 consecutive weeks. 10 charts will be audited every month and reported on in the monthly quality committee and quarterly in governing board with a goal of 90% and above for the next 4 months to ensure that the initial treatment plan is completed within 72 hours and any updated treatment plans are completed within 7 days for each stay longer than 7 days. The audit will also ensure that all problem areas that are being treated are documented on the treatment plan.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

September 18, 2023

Toni Long
Chief Executive Officer
Rainier Springs
2805 NE 129th Street
Vancouver, WA 98686

Re: Complaint #129088/2023-2563

Dear Ms. Long,

I conducted a state complaint investigation at Rainier Springs Hospital on 03/30/23 and exited on 04/10/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 06/20/23.

Hospital staff members sent a Progress Report dated 09/01/23, reviewed and approved on 09/12/23, that indicates all deficiencies have been corrected. The Department of Health accepts Smokey Point Behavioral Hospital's attestation that it will correct all deficiencies cited at Chapter 246-322 WAC regulations.

We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Mary New

Mary New, MSN, RN
Nurse Investigator