PRINTED: 06/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION (X3) BUILDING			X3) DATE SURVEY COMPLETED	
	504003 B. WING			С				
NAME OF PROVIDER OR SUPPLIER			D. WING	9	STREET ADDRESS, CITY, STATE, ZIP CODE	05/	18/2017	
TAME OF TROUBLE OR OUT ELEK					0601 STEILACOOM BLVD SW			
WESTERN	STATE HOSPITAL			٦	TACOMA, WA 98498			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
A 000	INITIAL COMMENTS		A	000				
	FEDERAL COMPLAI	NT INVESTIGATION						
	(DOH) in accordance Administrative Code (WAC Hospital Licensi	e Department of Health with Washington WAC), Chapter 246-320 ng Regulations, conducted complaint investigation.						
	Onsite dates: 5/8/201 Examination date num Intake number: 72756	nber: N/A					·	
	The investigation was Diane Sanders, RN, M Barrette, RN, BSN	conducted by: IN, NEA-BC and Deborah						
	found.	ON LEVEL DEFICIENCIES						
A 144	482.13(c)(2) PATIENT SETTING-	RIGHTS: CARE IN SAFE	Α.	144	Plan of Correction for each specific deficiency cited:		. •	
	setting. This STANDARD is not be a seed on observation review the facility environment for a patient an investigation of entering the shower/turns.	ght to receive care in a safe not met as evidenced by: n, interview, and record y failed to provide a safe ent (Patient #1) following a staff member (Staff A) ub room when Patient #1			(A 144) The hospital failed to provide a s environment for the patient and to impler security protections for patient safety. To the patient has the right to receive care ir setting, the following corrections will be n Policy 7.03 "Abuse and Neglect Program" will be updated to proguidance on minimizing the psychological impact to the patient during and after an investigation concluded. This includes notifying physician to assess the patient's status to determine if patient can been impacted and make recommendations to mitigate ris any negative impact to the patient can be set fine in the patient can be set fine i	ment o ensure n a safe nade: vide ent n is ng the s mental re has ek for		
			·		 The staff will not be returned to where the original allegation occuntil it has been reviewed by the Management Review Team. Training will be developed via 	curred		

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Event ID: FCPN11 Chief Executive Officer

If continuation sheet Page 1 of 7

educational memorandum for Supervisors and Physicians and include the requirement of the annual all staff Abuse and Neglect training on policy 7.03 "Abuse and Neglect Program" procedures.

Procedure/process for implementing the plan of correction:

- Updated policy 7.03 "Abuse and Neglect Program" to provide guidance on minimizing the psychological impact to the patient during and after an investigation is concluded.
- Supervisors and Physicians will receive training on the revised policy 7.03 "Abuse and Neglect Program" procedure training.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Human Resources will maintain a log of staff reassignments and return to duty.
- Human Resources will notify the Chief Clinical Officer when staff is ready to return to duty.
- The Chief Clinical Officer or designee will monitor the HR log and ensure physician recommendations occur regarding minimizing negative impact of patient before staff's return to duty, if patient care has been impacted.

Process improvement: actions incorporated into its Quality Assessment and Performance improvement (QAPI) Program:

 Investigation Department will perform a quarterly audit to ensure that staff will not be returned to the area where the original allegation occurred until it has been reviewed by the Management Review Team. This will be included in the Clinical Risk Management dashboard and reported to Patient Care Quality Council and Governing Body until 100% compliance has been reached for two consecutive guarters.

Individual Responsible:

• The Chief Clinical Officer

Date completed:

August 10, 2017

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIED BEPRESENTATIVE'S SIGNATURE

Chief Executive Officer

(X6) DATE /1.5

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This plan has been submitted to CMS, and may be altered in the future.

CMS may accept the plan as written, or it may require changes or adjustments to the plan, or other actions it deems necessary.

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Facility ID: 003283

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED	
		504003	B. WING			C 5/18/2017	
NAME OF PROVIDER OR SUPPLIER WESTERN STATE HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP (9601 STEILACOOM BLVD SW TACOMA, WA 98498		5/16/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 144	Findings include: 1. Observations of thall staff could enter that staff hallway. 2. Review of Staff Althey provided counse issues. Staff A did not personal care needs (ADL's) which would it amember Staff A enter while Patient #1 was was reported to the insame day the allegati investigation was star was removed that day was removed that day 4. Review of Patient were being treated for at the time of incident scheduled to be transithe facility as result of the allegation. After the patient became suicid watch with a staff me The record showed the statements "it's all my talk about it now." When about if someone was the patient replied "now might have been in the staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the statements "it's all my talk about it now." When a staff me The record showed the staff me The record showed th	ne shower/tub room revealed ne shower/tub room from the si job description revealed teling for mental health of provide care for patients' for activities of daily living include showers. It is reported by another staff ed the shower/tub room in the area. The incident envestigation department the on was reported. The ented on 1/11/2017. Staff A by from direct patient care. #1's record revealed they real mental health condition in the patient was deferred to another ward in their improvement prior to the allegation/incident the dal and was put on a 1:1 mber for several weeks. The patient making of fault" and "I do not want to then the patient was asked in the shower with them, "but indicated someone"	A 1	144			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504003 B. WING		C 05/18/2017				
NAME OF PROVIDER OR SUPPLIER WESTERN STATE HOSPITAL				٤	STREET ADDRESS, CITY, STATE, ZIP CODE 0601 STEILACOOM BLVD SW TACOMA, WA 98498		10/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
A 144	incident investigation stated, Staff A did not should not have been occur. 6. On 5/8/2017 at 1:1 was interviewed. Staff to decompensate after The patient became le express wanting to haw as put on 1:1 monitor prevent self harm. The about the incident the is right". Staff C had chave occurred between Staff C was not consult to return to the same conclusion of the inverpatient's behavior charthe alleged incident where the staff C was interviewed. Staff Consulted about allow ward at the conclusion D indicated they had cabout the allegations of Staff A but they were not to allow Staff A back of the sta	involving Staff A. Staff B provide care for ADL's and in an area where this would 0 PM Staff C a physician of C stated the patient began or the incident on 1/11/2017. The ses verbal and began to the patient would only say yould talk "when the time concerns about what may be staff A and Patient#1. The stigation. Staff C felt the stigation. Staff C felt the stigation. Staff C felt the stigation. Staff D a physician of D stated they were not ing Staff #A to return to the nof the investigation. Staff contacted administration involving Patient #1 and not included in the decision on the ward.	A	144			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		504003	B. WING _		C 05/18/2017	
NAME OF PROVIDER OR SUPPLIER WESTERN STATE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 9601 STEILACOOM BLVD SW TACOMA, WA 98498			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
A 144	9. On 5/18/2017 at 8: for Forensic Services about the decision to Staff M made the decithe allegation was not fact the patient had do the alleged incident. The patient's physician to the ward. 482.13(c)(3) PATIENT ABUSE/HARASSMENT The patient has the riof abuse or harassment This STANDARD is right Based on interview, in facility policies and proposition to adequately protect an incident of possible shower/tub area of the ward. Failure to immediately brought to the attention patients at risk for furth Findings include: 1. The facility policy 'Program'', policy 7.03 (Western State Hospi and prevent the occur to include: Prevention Training, Protecting, I and Responding''	OO AM, the Center Director (Staff M) was interviewed return Staff A to the unit. ision to return Staff A since is substantiated despite the ecompensated directly after Staff M did not consult with his about the return of Staff A TRIGHTS: FREE FROM NT- Interpretation of the staff A record review and review of ocedures the facility failed a patient (Patient #1) from the exploitation in the the patient's (Patient #1) care of assess the situation when on of the staff places ther exploitation.	A 1	44 Plan of Correction for each specific deficiency cited: (A 145) The hospital failed to adequate the patient from an incident of possible exploitation in the shower/tub area and immediately assess the situation when to the attention of the staff. To ensure t patient's right to be free from all forms and harassment, the following correction made: Policy 7.03 "Abuse and Program" will be update address protecting the patient from exploitation, include immediately ensuring the is safe and reporting to future incidents. Training will be developingled updated training 7.03 "Abuse and Neglect Program." Procedure/process for implementing of correction: The updated policy 7.03 and Neglect Program wupdated to include prote patient from exploitation immediately ensuring the is safe and reporting to future incidents. Training will be developeducational memorandu Nursing staff regarding of the patient from the protein forms and the protein forms will be developeducational memorandu.	brought ne of abuse ns will be Neglect d to atient ng e patient brevent ed to on policy t the plan "Abuse ill be cting the including e patient brevent ed via m for	

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Policy 7.03.

 The required annual Abuse and Neglect training will be updated to include protecting the patient from exploitation, including immediately ensuring the patient is safe and reporting to prevent future incidents.

Monitoring and tracking procedures to ensure the plan of correction is effective:

- Organizational Development will provide competency evaluation as part of the Abuse and Neglect Training. All staff must pass the competency in order to provide patient care.
- Organizational Development will track competency and 90% testing compliance will be met.

Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:

 Organizational Development will report the results and actions taken to Patient Care Quality Council and the Governing Body on a quarterly basis.

Individual Responsible:

 Director of Organizational Development

Date completed:

August 31, 2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		504003	B. WING				C /4.9/2017	
NAME OF PROVIDER OR SUPPLIER WESTERN STATE HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 9601 STEILACOOM BLVD SW TACOMA, WA 98498				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
A 145	shower/tub area while shower. The charge door to ask Patient #/ anyone was in the sh replied no one was in charge nurse then ca about the incident. 3. On 5/9/2017 at 1:2 interviewed. Staff B saking the patient if a with them. The patient the shower room and Staff B went on to say the shower area and when the allegation w 4. On 5/10/2017 at 1 were reviewed with the Staff F stated Staff B	rted Staff A had entered the e Patient #1 was in the nurse (staff B) went to the I if they were ok and if ower with them. The patient shower with them. The lled the nursing supervisor 25 PM, Staff B was stated they remembered nyone was in the shower not peeked their head out of said no one was with them. If they should have inspected tub room area immediately was made. 1:00 AM, the above events ne nurse manager (Staff F).	A	145				