DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A 000	INITIAL COMMENTS	A 000		

MEDICARE RECERTIFICATION SURVEY

The Washington State Department of Health (DOH) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety survey.

Health survey onsite dates: 05/08/17 through 05/18/17; and 5/23/17 through 05/25/17. Follow-up visit onsite date: 06/05/17

The survey was conducted by:
Elizabeth Gordon, RN, MN
Marieta Smith, RN, MN
Paul Kondrat, RN, MN, MHA Joy Williams, RN, BSN Cathy Strauss, RN, BSN Lisa Mahoney, PHA, MPH Alex Giel, PHA, REHS Robin Munroe, PHA, RS
Tyler Henning, PHA, ScM, MHS
Kimberly Metz, RN, MSN (orientee)

The Washington Fire Protection Bureau conducted the fire life safety (F/LS) inspection on 05/08/17 through 06/01/17 (See attached F/LS report).

DOH staff found the facility not in compliance with the following Conditions of Participation:

42 CFR 482.12 Governing Body
42 CFR 482.13 Patient Rights
42 CFR 482.21 Quality Assessment and Performance Improvement
42 CFR 482.23 Nursing Services
42 CFR 482.26 Radiological Services 42 CFR 482.30 Utilization Review
42 CFR 482.41 Physical Environment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Chief Executive Officer	7/11/17

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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A 000	Continued From page 1 42 CFR 482.56 Rehabilitation Services During the course of this survey, the DOH surveyors and Washington Fire Protection Bureau inspectors determined that there was high risk of serious harm, injury, and death due to the scope and severity of patient care and fire and life safety deficiencies. IMMEDIATE JEOPARDY (IJ) was declared as follows: IJ #1 - Declared on 05/08/17 at 4:45 PM - The hospital did not ensure that patients, staff, and visitors were protected from harm in the event of a fire. The hospital initiated corrective action on 05/08/17 at 7:30 PM. The state of IJ was removed on 05/23/17 at 8:40 AM. (Cross reference: F/LS inspection report, Tags K0271, K0355, K0712) IJ #2 - Declared on 05/09/17 at 4:25 PM - The hospital did not ensure that patients, staff, and visitors were protected from the risk of harm in the event of a fire. The hospital initiated corrective action on 05/09/17 at 6:30 PM. The state of IJ was removed on 06/01/17 (Cross reference: F/LS inspection report, Tag K0353) IJ #3 - Declared on 05/09/17 at 4:25 PM - The hospital did not ensure that patients, staff, and visitors were protected from the risk of harm in the event of a fire. The hospital initiated corrective action on 05/09/17 at 6:30 PM. The state of IJ was removed on 06/01/17. (Cross reference: F/LS inspection report, Tag K0345) IJ #4 - Declared on 05/11/17 at 4:15 PM - The Governing Body did not ensure that the quality of care provided to patients met the patients' needs. The hospital initiated corrective action on 05/15/17 at 9:40 AM. The state of IJ was	A 000		

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A 000	Continued From page 2 removed on 05/24/17 at 2:00 PM. (Cross reference: Health survey report, Tag A0049, Tag A1134) IJ #5 - Declared on 05/12/17 at 2:45 PM - The hospital did not ensure that patients were provided care in a safe setting. The hospital initiated corrective action on 05/15/17 at 3:15 PM. The state of IJ was removed on 05/24/17 at 2:00 PM. (Cross reference: Health survey report, Tag A0144) IJ #6 - Declared on 05/15/17 at 1:30 PM - The hospital did not ensure that patients were provided care in a safe setting. The hospital initiated corrective action on 05/15/17 at 4:45 PM. The state of IJ was removed on 05/24/17 at 2:00 PM. (Cross reference: Health survey report, Tag A0145) IJ #7 - Declared on 05/17/17 at 9:00 AM - The Governing Body failed to ensure that hospital provided care to patients with medical needs. The hospital initiated corrective action on 05/17/17 at 4:45 PM. The state of IJ was NOT REMOVED at the time of the survey exit conference on 05/25/17 at 11:30 AM. Surveyors returned to the hospital on 06/05/17 for a follow-up visit. The state of IJ was REMOVED on 06/05/17 at 1:30 PM. (Cross reference: Health survey report, Tag A0049, Tag A0396; A1134).	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the	A 043		

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A 043	Continued From page 3 governing body ... This Condition is not met as evidenced by: Based on observation, interview, record review, and review of hospital policies and procedures and Governing Body bylaws, the Governing Body failed to develop and maintain effective systems that ensured that patients received high quality healthcare that met their needs in a safe environment. Failure to ensure patients are provided with care that meets acceptable standards of practice and meets the patient's healthcare needs in a safe environment risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. The hospital's Governing Body bylaws (January 2017) showed that the Governing Body's purpose is to establish an organized medical staff and other hospital departments whose responsibility would be to ensure high quality patient care. The bylaws showed that Governing Body will establish and implement an effective program for improvement of performance throughout the hospital. 2. Observation interviews, record review, review of hospital policies and procedures, and review of the hospital's quality and Utilization Management program showed the following: a. The Governing Body failed to ensure that medical care providers were considered an integral part of the patient's health care team; to review professional services as part of the utilization review process; and to include medical	A 043	**Plan of Correction for each specific deficiency cited:** **(**A043**)** The hospital failed to develop and maintain effective systems that ensured patients received high quality healthcare that met their needs in a safe environment. To ensure an effective governing body to carry out functions of the hospital the following corrections will be made: • See A 049 Item 1, 2, 3, 4 • See A115, A 263, A 385, A 528, A 652, A 700, A 1123.	

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A 043	Continued From page 4 care outcomes as part of the hospital's quality program. Cross Reference: A0049, Item #1 b. The Governing Body failed to ensure that the hospital developed and implemented an effective process for referring patients to health care consultants and for considering and acting on recommendations made by consultants as part of the treatment planning process. Cross Reference: A0049, Item #2 c. The Governing Body failed to ensure that medical staff members developed and implemented care plans for patients with physical rehabilitation needs Cross Reference: A0049, Item #3 d. The Governing Body failed to ensure that medical staff members developed and implemented care plans for patients with nutritional needs Cross Reference: A0049, Item #4 3. On seven occasions during the survey, surveyors determined that conditions existed at the hospital that posed Immediate Jeopardy to the health and safety of patients. Due to these findings and the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.23 Nursing Services; 42 CFR 482.26 Condition of Participation for Radiological	A 043		

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A 043	Continued From page 5 Services; 42 CFR 482.30 Condition of Participation for Utilization Review; 42 CFR 482.41 Condition of Participation for Physical Environment; and 42 CFR 56 Condition of Participation for Rehabilitation Services, the Condition of Participation for Governing Body was NOT MET. Cross Reference: Tags A0115, A0263, A0385, A0528, A0652, A0700, A1123.	A 043		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This Standard is not met as evidenced by: Item #1 - Medical Care Quality Assessment and Interdisciplinary Team (IDT) Integration Based on interview and review of the hospital's quality program, the Governing Body failed to ensure that medical care providers were considered an integral part of the patient's health care team; and to include medical care outcomes as part of the hospital's quality program. Failure to include the medical care provider as an integral part of the IDT and to include medical care as part of the hospital's quality program risks delivery of substandard care and poor health care outcomes. Findings included: 1. On 5/17/2017 at 9:15 AM, Surveyors #5, #6, #7, #8, #9, and #10 interviewed the Chief Medical	A 049	**Plan of Correction for each specific deficiency cited:** (A049) #1The hospital failed to ensure that medical care providers were considered an integral part of the patient's health care team, and to include medical care outcomes as part of the hospital's quality program. To ensure medical care quality assessment and interdisciplinary team integration the following corrections will be made: • The medical care providers are members of the multidisciplinary treatment team for all patients under their care. They will work in collaboration with the Attending Psychiatrists to ensure that all medical conditions/illnesses are appropriately addressed in the Master Treatment Plan. The treatment team will engage the medical providers to ensure treatment plan reviews are adjusted to account for any changes in their patients' medical conditions. • See A 273 • See A 658	

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A 049	Continued From page 6 Officer (Staff Member #M11), the Chief Nursing Officer (Staff Member #M12), the Deputy of Hospital Operations (Staff Member #M9), and the Chief of Quality (Staff Member #M4) regarding how medical physicians interface with the psychiatric care providers. The CMO stated that medical physicians were considered "consultants" and were not part of the psychiatric care team unless they were "invited". He stated each physician practices independently. Peer review was conducted for individual hospital cases but there were no medical outcome indicators for the patient population. 2. Review of the hospital's quality program and Utilization Management program confirmed the findings above. Cross Reference: A0273, A0658 Item #2 - Referrals to Health Care Consultants Based on observation, interview, and record review, the Governing Body failed to ensure that the hospital developed and implemented an effective process for referring patients to health care consultants and for considering and acting on recommendations made by consultants as part of the treatment planning process. Failure to consider patient care recommendations made by health care consultants in the patient's treatment planning process risks deterioration in the patient's health status and poor health care outcomes. Findings include: 1. On 5/11/2017 at 2:10 PM, Surveyors #5, #6,	A 049	**Plan of Correction for each specific deficiency cited:** (A049) #2The hospital failed to consider patient care recommendations made by health care consultants in the patient's treatment planning process risking deterioration in the patient's health status and poor health care outcomes. To ensure quality of care the following corrections will be made: • ICSM Management Bulletin 17-07 was issued May 17, 2017 outlining new processes for consultations and incorporating recommendations into the patient treatment plan. • New policy and forms were created to address Consultations. WSH Policy 11.16 Medical Services Consultation and Consult Form WSH 14-55. • Nurses and Physicians were educated on the new practice. • A Rapid Lean Event will be held to develop an effective consultation process. • See A 396 • See A 1134	

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A 049	Continued From page 7 and #7 interviewed the Chief Executive Officer (Staff Member #M14) , the Chief Medical Officer (Staff Member #M11) the Deputy of Hospital Operations (Staff Member #M9), and the Chief of Quality (Staff Member #M4) about the medical referral process. The CMO stated the medical consultation process relies on "referral by exception", i.e. no automatic consults based on protocol or standard. He stated that the medical staff relies on issues identified by the nursing staff or medical problem concerns voiced by patients for referrals to be initiated. 2. On 5/17/2017 at 9:15 AM, Surveyors #5, #6, #7, #8, #9, and #10 interviewed the Chief Medical Officer (Staff Member #M11), the Chief Nursing Officer (Staff Member #M12), the Deputy of Hospital Operations (Staff Member #M9), and the Chief of Quality (Staff Member #M4) regarding how referrals to health care consultants are tracked. The CMO stated that referrals were currently not being tracked. 3. Observations, interviews, and medical record review confirmed that the hospital did not have an effective process that ensured health care consultant recommendations were part of the patient's treatment plan. Cross Reference: A0049 Items #3 and #4, A0396, A1134 Item #3 - Medical Screening and Referral for Rehabilitation Services Based on observation, interview, record review, and review of hospital policies and procedures, the Governing Body failed to ensure that medical staff members developed and implemented care	A 049	**Procedure/process for implementing the plan of correction:** • ICSM Management Bulletin 17-07 was issued May 17, 2017 outlining new processes for consultations. This was emailed to all staff, posted on the Policy Page and to the Electronic Bulletin Board (EBB). • New policy and forms were created to address consultations. WSH Policy 11.16 Medical Services Consultation and Consult Form WSH 14-55. The Policy and Forms Committee approved and posted to the Electronic Policy Manual for all staff access. • Nurses and physicians were educated on the new practice by the Chief Medical Officer and RN4's. • A Rapid Lean Event will be held to develop and implement an effective consultation process. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • RN3's will audit treatment plan addendums to ensure consultation recommendations are included. • The Chief Medical Officer will coordinate with the Quality Department to audit the consultation process, data and actions taken will be reported to Patient Care Quality Council (PCQC) and the Governing Body.	

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A 049	Continued From page 8 plans for patients with physical rehabilitation needs, as demonstrated by Patient #KM1. Failure to identify patients with physical rehabilitation needs and develop and implement treatment plans to meet those needs risks deterioration of the patient's health and prolonged hospitalization. Findings included: 1. The hospital's policy and procedure titled, "Management of the patient at risk for falls" (Nursing Standard Protocol #339; Revised March 2017), under the heading: Area of Responsibility", read: "D. Physical Therapy Referral if needed ... "4. Refer for PT eval [evaluation] if: A. High Fall Risk (Tinetti score 0-19). B. Pt is non-ambulatory upon admit or with change of condition affecting ambulation". Under the heading "F. Interdisciplinary Management Interventions", the policy read: "9. Consult with physical and occupational therapy to plan a program to increase patient's endurance and strength." 2. The hospital's policy and procedure titled "Medical Records Procedures Procedure: Rehabilitative Services Consult Referral" (WSH 23-59; Revised January 2013) read: " ...5. Possible Criteria for Referral: ...E. Physical Therapy deficit in: i. Range of Motion; ii. Muscle Strength; iii. Mobility (Transfers/Ambulation); iv. Neuromuscular or Musculoskeletal conditions". 3. On 05/08/17 at approximately 2:30 PM, Surveyor #9 observed patient #KM1, a 58 year old admitted on 04/26/17 for competency restoration, sitting in a wheelchair that was too	A 049	**Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Medical Officer will work with the Quality Department to audit the consultation process, data and actions taken will be reported to Patient Care Quality Council and the Governing Body. **Individual Responsible:** • Chief Medical Officer **Date completed:** • January 15, 2018	

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A 049	Continued From page 9 small for the patient. The patient's feet were located on the foot pedals causing his knees to be bent at chest level. The patient's hands were placed on the wheels to propel the wheelchair, as a result, the patient's arms were bent and angled outward and elbows were above shoulder level. 4. Review of #KM1's medical record revealed the following: a. On 04/08/17 while in jail, Patient #KM1 began exhibiting symptoms of left sided numbness, and weakness. The patient was evaluated by the jail nurse and found to have slurred speech, nystagmus (double vision), and his left pupil was larger than the right pupil. Patient #KM1 was transferred to an acute care hospital where he was diagnosed with an acute thromboembolitic cerebellar stroke. Review of the hospital chart revealed that the patient was referred for inpatient physical rehabilitation on 04/12/17. The hospital discharge summary dated 04/22/17 read: "Patient seen in AM rounds. Still can't close right eye or puff up right cheek. But ambulating fine in the hallways. Medically stable to discharge." The patient KM#1 was returned to jail. b. On 04/26/17, the patient was admitted to Western State Hospital for competency restoration. The Admission History and Physical Examination (Form WSH 23-55C) completed on 04/26/17 (signed by the physician on 05/03/17) read: "B. History of present illness ... History recent CVA [stroke] with left side paresthesia, dysphagia, and right facial weakness." On Page 4, the history and physical read: " ....decreased sensory on left side of body and face ....unable to test gait secondary unsteady gait". The medical record did not include a physician order for a	A 049		

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A 049	Continued From page 10	A 049		

Physical Therapy Referral/Consult or Speech Therapy consult as directed by hospital policy.

c. The Initial Nursing Assessment (Form WSH 23-60A) completed on 04/26/17 read: "Safe patient handling and movement assessment: ...2. Patient Level of Assistance: Stand-by-assist; 3. Weight bearing capability: ...partial; ...5. Applicable conditions likely to affect transfer/repositioning techniques ... paralysis/paresis; 6. Assistive Devices ...Wheelchair; Tinetti Test (Fall Risk Index): Balance and Gait score 16". A Tinetti Score of less than 20 indicated that patient was at high risk for falls. The medical record did not include a nursing referral for physical therapy consult based a Tinetti Score less than 20, per hospital policy.

5. On 05/08/17 at approximately 3:15 PM, Surveyor #9 interviewed Patient #KM1. At the time of the interview Patient #KM1 stated that both of his legs were numb, and that nothing works on his right side. The patient stated that he had been walking every day at the previous hospital with the help of staff or with a walker. He stated that he had not been walking since he came here.

6. On 05/08/17 at approximately 3:00 PM, Surveyor #9 interviewed Staff Member #KM 1. At the time of the interview, Surveyor #9, asked Staff Member #KM1 to look at the patient in the wheelchair. Staff Member KM#1 verified the wheelchair was too small for the patient. During the interview, Staff Member #KM1 revealed that Patient #KM1 had been using a walker on admission. Staff Member #KM1 stated that walkers were not allowed because they could be used as a weapon. Because of that, Patient

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A 049	Continued From page 11 #KM1 was given a wheelchair. Staff member #KM1, stated Patient #KM1 had not been walking since he had been admitted to the hospital. Staff Member #KM1 confirmed that hospital staff members had not conducted a wheelchair assessment for this patient. The staff member stated there was only one wheelchair on the ward and all patients used that wheelchair. At the time of the interview, Staff Member #KM1 contacted the Equipment Manager (Staff Member #M10), and the patient received a larger wheelchair. Staff Member #KM1 confirmed that there was no physical therapy consult ordered for Patient #KM1 by medical or nursing staff members. Item #4 - Medical Orders for Nutritional Care Based on interview and record review, the Governing Body failed to ensure that medical staff members developed and implemented care plans for patients with nutritional needs, as demonstrated by Patient #JW2. Failure to identify patients with impaired nutrition and develop and implement treatment plans to meet the patient's nutritional needs risks deterioration of the patient's health and prolonged hospitalization. Findings include: On 05/16/17 at 2:30 PM, Surveyor #10 reviewed the medical records of Patient #JW2 and interviewed the Ward Administrator for the patient's treatment unit (Staff #JW6). This record review and interview showed the following:	A 049	See A 049 #2	

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WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A 049	Continued From page 12 1. The patient had a long history of refusing to eat. On 03/07/17, the patient underwent a surgical procedure for insertion of a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube surgically inserted through the patient's abdominal wall into the patient's intestine) as an access for supplemental feeding. 2. On 03/10/17, a registered dietician (Staff Member #JW3) performed a dietary consult for the patient. She recommended that the PEG tube feedings be increased from four cans of dietary supplement a day to six cans per day to maintain nutritional and caloric needs. The dietician also noted that the patient was dehydrated and recommended increasing the amount of "free water" (additional water given during feedings) to 450 ml per day. On 04/07/17, the patient's physician (Staff Member #JW4) ordered PEG tube feedings four cans a day with no additional free water. On 04/13/17 a different physician (Staff Member #JW5) wrote an order that stated, "Refer to Dietary for PEG tube feeling adjustment. Weekly weight and chart." 3. On 04/24/17, the dietician (Staff Member #JW3) wrote a nutritional follow up note. She wrote that patient had lost 9.8 lbs. and recommended that the PEG tube feedings be increased to six cans of supplement a day. She wrote, "Refer to progress noted dated 03/10/17 by this writer for details, current fdg [feeding] amount not sufficient." 4. On 05/16/17 at 3:25 PM the Ward Administrator (Staff Member #JW6) and a registered nurse (Staff Member #JW7) confirmed that the registered dietician recommendations were not implemented and that the updated order had not been placed on the treatment orders to	A 049		

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A 049	Continued From page 13 alert staff to increase the PEG tube feedings. 482.13 PATIENT RIGHTs-	A 049		
A 115	A hospital must protect and promote each patient's rights. This Condition is not met as evidenced by: Based on observation, interviews, document reviews, and review of hospital policies and procedures, the hospital failed to protect and promote patient rights. Failure to protect and promote each patient's rights risks the patient's loss of personal freedom, privacy, dignity, and psychological harm. Findings included: 1. The hospital failed to ensure patients receive care in a safe setting which safeguards vulnerable individuals from self-harm and harm from others; 2. The hospital failed to release patients from seclusion or restraints at the earliest possible time when documented behavior reflected no imminent risk of danger; 3. The hospital failed to monitor the patient in restraints or seclusion as directed by hospital policies and procedures; 4. The hospital failed to communicate the results of patient complaints prior to closure of the complaint; 5. The hospital failed to maintain confidentiality of patient medical records.	A 115	**Plan of Correction for each specific deficiency cited:** (A 115) #1-5 The hospital failed to protect and promote patient's rights, risk the patient's loss of personal freedom, privacy, dignity and psychological harm. To ensure the hospital protect and promote each patient's rights, the following corrections will be made: • #1-3: Nursing staff will receive training on: 1. Safeguards against self-harm and harm from others for vulnerable individuals. 2. Releasing a patient from Seclusion or Restraint (S/R) when there is no evidence of immediate risk of danger. 3. Monitoring the patient in seclusion or restraint. • Organizational Development will expand New Employee Orientation Seclusion and Restraint Training to include items #1-3. • Seclusion/Restraint Audit Tool will be reviewed and updated as needed to assist in monitoring patients in S/R • #4 See TAG A 123	

			• #5 See TAG A 146 **Procedure/process for implementing the plan of correction:** • Direct care nursing staff will receive documented training. • New Employee Orientation and Annual Seclusion and Restraint training will be updated to include items #1-3. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Updated Seclusion/Restraint Audit Tool will be used for 15 minute monitoring. • RN3 will audit to ensure appropriateness and compliance to the policy. • RN4 will analyze compliance data and develop plan of correction as needed. • Deputy Chief Nursing Officer will monitor and track audits to ensure 95% compliance. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • Chief Nursing Officer will report on the seclusion and restraint compliance and any actions taken to correct deficiencies in the nursing report to Patient Care Quality Council and Governing Body quarterly. **Individual Responsible:** • Chief Nursing Officer **Date completed:** • March 31, 2018	

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A 115	Continued From page 14 The cumulative effects of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights. Due to the scope and severity of deficiencies cited under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross-Reference: Tags A0123, A0144, A0145, A0146, A0174, A0175.	A 115		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION- At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: Based on interviews, document review, and review of hospital policies and procedures, the hospital failed to ensure the results of the grievance investigation were shared with the patient for 3 of 4 grievances reviewed (Patients #K14, #K15, #K16). Failure to inform the patient of the results of the grievance investigation violates their right to be informed and risks patient safety for unmet care needs. Findings included:	A 123		

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A 123	Continued From page 15 1. The hospital policy and procedure titled, "Patients, Comments, Grievances, and Resolution" (Policy 10.07, Effective Date May 1, 2017) read: "Policy: ...WSH provides timely response to patient complaints, including allegations of patient rights violations, ensuring the patient receives fair and courteous treatment ...G. Grievance Process..2. If the grievance cannot be resolved within 7 days, the PRG [Patient Rights and Grievances] [department] sends a letter to the patients that states the anticipated date when the grievance response will be complete..3. The PRG Director will provide the investigation results in a closure letter to the patient within 30 days of receipt of the grievance. The closure letter includes: a. The hospital's decision; b. Name of the hospital contact person; c. Steps taken on behalf of the patient to investigate the grievance; d. Results of the grievance process; and e. Date of completion." 2. Surveyor #7 selected four patient complaints for review of process and resolution. Sources included the patient grievance log. Each complaint was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with the patient who filed the grievance. 3. On 05/23/17, Surveyor #9 reviewed the charts of two patients (Patient #K14 and Patient #K15) who filed grievances that were then forwarded to Clinical Risk Management (CRM) for investigation. Surveyor #9 noted the following: a. Patient #K14 filed a letter of complaint on 05/02/17 making allegations of staff abuse and neglect of a peer patient. A review of the grievance log indicated the complaint was closed.	A 123	**Plan of Correction for each specific deficiency cited:** (A 123) The hospital failed to ensure the results of the grievance were shared with the patient. To ensure the hospital resolves grievances and provides the patient with written notices of its decisions, the hospital will provide closure letters for patients after their grievances have been forwarded to Investigation's Department, Clinical Risk Management (CRM), or other departments for follow up. **Procedure/process for implementing the plan of correction:** • Patient Rights and Grievances (PRG) Committee has designated a team member responsible for grievances. • PRG member will provide each patient a letter informing them where his/her grievance was sent and he/she will receive a letter of closure when the findings are complete. • When Clinical Risk Management investigates a grievance, they will provide a closure letter to the patient. CRM will provide the PRG member assigned a copy of the closure letter by attaching to the Administrative Report Of Incident (AROI) in the database. • When Investigations is assigned an AROI, their Program Coordinator will provide a closure letter to the patient. Investigations will provide PRG will the write a closure letter by attaching to the AROI in the database. • When an AROI is forwarded to the center, safety or another department for resolution, it will be the responsibility of the PRG team member assigned to follow up with them to provide closure information to the patient. • PRG will work with each discipline/area and the patient to ensure the patient can read English. If the patient cannot, closure will be provided verbally in addition to the letter. • WSH Policy 10.07 Patient Comment,	

			Grievance and Resolution will be updated to reflect the changes. **Monitoring and tracking Procedures to ensure the POC is effective** • PRG will use their database to ensure timely delivery of responses to patients. • PRG will meet with Investigations, CRM or departments when concerns arise and develop corrective actions to implement immediately. • PRG checks patient satisfaction and ensures patients receive closure letters by providing a brief satisfaction form with their closure letter. This letter can be mailed back to the PRG office. • PRG will conduct monthly audits by calling 5 patients from each center that did not return their form and ask if they received resolution/closure letter and if they were satisfied with the resolution. **Process Improvement: actions incorporated into its QAPI program** • PRG will present their monthly audit on patient grievance data adding patient satisfaction and department closure letters monthly to QAPI. • Quarterly, PRG will report data and recommendations for corrections needed to Patient Care and Quality Council. **Individual Responsible** • Patients' Rights and Grievance Director **Date Completed** • January 15, 2018	

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A 123	Continued From page 16 Review of the grievance file showed a letter dated 05/03/17 from the Patient Rights Investigator (Staff Member #K12) had been sent to the patient informing the patient the grievance had been forwarded to the Clinical Risk Management for review. A second letter dated the same day from the Director of Patient Rights and Grievances (Staff Member #K13), was sent to the patient informing her the allegations had been forwarded to Clinical Risk Management to investigate and stated "No further action will be taken." b. Patient #K15 filed a letter of complaint on 04/20/17 making allegations of staff harassment and abuse. A review of the grievance log indicated the complaint was closed. Review of the grievance file showed a letter dated 04/20/17 from Staff Member #K12 had been sent to the patient informing the patient the grievance had been forwarded to the Clinical Risk Management for review. A second letter dated 04/21/17 from Staff Member #K13, was sent to the patient informing her the allegations had been forwarded to Clinical Risk Management to investigate and stated "No further action will be taken." 4. On 05/23/17, Surveyor #7 reviewed the charts of two patients who filed grievances that were then forwarded to Clinical Risk Management (CRM) for investigation. Surveyor #7 noted the following: a. Patient #K16 filed a letter of complaint on 04/22/17 making allegations of staff abuse. A review of the grievance log indicated the complaint was closed.	A 123		

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A 123	Continued From page 17 b. Review of the grievance file showed a letter dated 04/24/17 from Staff Member #K12 had been sent to the patient informing the patient the grievance had been forwarded to the Clinical Risk Management for review. A second letter dated 04/25/17 from Staff Member #K13, was sent to the patient informing her the allegations had been forwarded to Clinical Risk Management to investigate and stated "No further action will be taken." 5. On 05/23/17 at 9:00 AM, Surveyors #7 and #9 interviewed the Director of Patient Rights and Grievances (Staff Member #13) about the hospital's complaint and grievance process. The discussion included how patients are provided a written notice of steps taken to investigate their grievance and how the results of the investigation are then communicated with the patient. For Patients #K14, #K15, and #K16 there was no action documented indicating the patients concern had been addressed or resolved. Staff Member #K13 indicated that grievances or allegations of abuse are referred to CRM for investigation and the grievance is closed. She was unsure who informed the patient about the results of the investigation once it was referred to CRM. Staff Member #K13 acknowledged that their office did not receive a copy of the CRM investigation report. 6. On 05/23/17 at 11:05 AM, Surveyors #7 and #9 interviewed the Director of Clinical Risk Management (Staff Member #K11) about the hospital's process for providing patients written notice of steps taken to investigate their grievance and how the results of the grievance investigation by the Clinical Risk Management Department is disseminated. Staff Member #K11 indicated that the results of the investigation are	A 123		

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A 123	Continued From page 18 shared with the Center Director and the Center's Senior Nurse Leader but was uncertain if those results are then shared with the complainant. The Director of Clinical Risk Management acknowledged that no formal investigation report is sent to the Grievance Coordinator for closure with the patient.	A 123		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING- The patient has the right to receive care in a safe setting. This Standard is not met as evidenced by: Item #1 - Security Based on observation, interview, and review of hospital policies and the manufacturer's instructions for use, the hospital failed to develop policies and procedures for use of a hand-held metal detector that reflected the manufacturer's instruction for use; and to educate staff regarding use of the detector. Failure to ensure that staff used the hand held metal detector according to the manufacturer's directions for use places patients and staff at risk of injury or harm from contraband (prohibited items) brought into patient care units. Reference: Garrett Metal Detector Super Scanner User's Manual: "The Audio Alert also indicates battery condition. When approximately 10% of battery life remains, the sound when metal is detected changes from a warble to a steady tone...When approximately 10% of battery life remains, the Amber Alert Light will turn on, indicating the battery needs to be replaced or	A 144		

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A 144	Continued From page 19 recharged." Findings included: 1. Review of hospital's policy and procedure titled, "Wanding - Use of Hand-Held Metal Detector Wand" (Approved Date 1/17) read: "The wand has a simple on/off switch. A green light indicates the scanner is on... When the green light no longer appears and alarms no longer sound, the battery must be changed." The policy and procedure was not written in accordance with the manufacturer's directions for use. 2.On 05/10/17 at 10:30 AM, a security officer (Staff Member #A5) scanned Surveyor #1 using the unit's metal detector wand prior to entering unit E2. When the security officer turned on the metal detector wand, the detector immediately started beeping, and amber and red lights started flashing. An interview with the security officer at the time of the observation showed the officer did not know that the batteries in the wand needed to be replaced or recharged.	A 144	**Plan of Correction for each specific deficiency cited:** (A 144) #1 The hospital failed to develop policies and procedures for use of hand-held metal detectors that reflected the manufacturer's instruction for use. To ensure the hospital provides care in a safe setting the following corrections will be made: • Develop a new procedure for specialty detectors that complies with manufacturer's instructions for use, to include: operability testing, inspection, and maintenance of hand-held metal detector scanning equipment used. • Policy regarding searches (WSH Policy 13.06) will be updated. • Ward Administrators, RN's, Organizational Development instructors and Security Supervisors will be trained as trainers on the updated policy and procedure. • All ward staff that participate in wanding and searches of patients will be trained using the updated wanding competency and search policy and procedure. **Procedure/process for implementing the plan of correction:** • The Policy and Forms Committee will review and update the policy and procedures consistent with the manufacturer's recommendation for use, testing, inspection and maintenance of hand-held metal detector scanning equipment. • The Safe Operations Team will develop a training that directs the use, testing, inspection and maintenance of hand held metal scanning equipment. • All supervisors who will train the ward staff will participate in a train-the-trainer course on the updated expectations. • All staff that participate in wanding patients will be trained in the use, testing, inspection and maintenance of the hand held metal scanning equipment.	

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

- The Safe Operations Team, and Ward Administrators will round 2x's a month and review samples of those using, testing, inspecting and maintaining hand-held metal detectors to determine compliance.

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

- Results of these spot audits will be provided to the Patient Care and Quality Council and Governing Body on a quarterly basis until 95% compliance has been met for four consecutive months.
- Once 95% compliance is met for four consecutive months, we will consider the process effectively demonstrated and will reduce monitoring to yearly.

Individual Responsible:

- Chief of Safety and Security

Date completed:

- January 15, 2018

Item #2 - Environmental Safety-

Based on observation, interview and review of hospital's policy and procedures, the hospital staff failed to maintain a safe patient care environment by effectively conducting environmental safety rounds and observing patients as directed by hospital policy.

Failure to protect patients from self-harm and harm by other patients poses a serious threat to the health and safety of all patients, which may result in serious injury and death.

Plan of Correction for each specific deficiency cited:

(A 144) #2 The hospital failed to maintain a safe patient care environment by effectively conducting environmental safety rounds and observing patients as directed by policy. To ensure patients receive care in a safe setting the following corrections will be made:

- CFS admission wards have changed the definition of contraband/restricted items to include sporks, flex pens and batteries
- Training conducted in May emphasized the importance of conducting environmental safety rounds.
- An inventory system was developed to account for items that should be checked in and out such as sporks and flex pens. When an object is not returned to the inventory system, a ward search is ordered.
- An immediate Clinical Safety Measure (ICSM) Bulletin Updated 17-05 was sent out which directed removal of unsafe items and addressed specialized staffing.
- Patients with a history of assault or ingestion of foreign objects will be identified upon admission and the information will be communicated to the ward.
- Patients who assault more than twice in one week will be referred for case conference.
- See A 145.

Procedure/process for implementing the plan of correction:

- All staff were notified of the Immediate Clinical Safety Measure (ICSM) Bulletin, through email, posting to EBB, Policy Page, and Ward Administrator notification for each ward.
- CFS admit wards are searched 2x a week.
- The CFS and PTRC Admissions Coordinators will request prior hospital records from the HIMS Department for a returning patient.
- History of assault or ingestion of foreign objects information will be communicated to the ward upon admission.
- Shift reports will document a history of assault, history of ingestion, and history of falls.

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

- Security reports will be reviewed in the ELT huddle for immediate feedback on contraband and actions taken to ensure patient safety.
- RN3 will review 10% of the shift reports

			monthly to ensure reporting of assaults, ingestion of foreign objects and falls. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief of Safety and Security will report results of ward searches and actions taken to Patient Care Quality Council (PCQC) and Governing Body quarterly report. QAPI will analyze the results on a quarterly basis for trends, spikes, etc., and forward action recommendations to Patient Care Quality Council. • The Chief Nursing Officer will report the audit results of assaults, ingestion of foreign objects, and falls quarterly to Patient Care Quality Council and Governing Body until 90% compliance has been met for two consecutive quarters. **Individual Responsible:** • Chief Nursing Officer **Date completed:** • January 15, 2018	

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A 144	Continued From page 20 Findings included: 1. Review of hospital policies, procedures, and directives showed the following: a. The hospital policy titled, "Management of the Patient Exhibiting Potential for Suicide (Suicide Watch)" (Standard Protocol 305; Revised March 2017) states in part: "A patient at risk for life-threatening self-injurious behavior may also place on constant or close suicide watch. ...Close Suicide Watch: A patient is assessed to be a moderate risk for suicide. ...The RN assigns staff member to maintain view of the patient by direct visual observation at all times and be within close enough proximity for immediate intervention. b. The hospital policy titled, "Specialized Staffing" (Policy 8.03; Effective March 15, 2017) read: "Specialized staffing is allowed for the following reasons: ...Danger to Self (DTS): 1:1 or 2:1 coverage ordered by a physician to help the patient refrain from self-injury. ...Employees providing monitoring for all patients will: 1. Know why the patient requires monitoring and what specific behaviors are expected of the staff. ...4. Know how to intervene to prevent patient harm." ..."Specialized staffing includes the following staffing ratios and monitoring parameters: One to One (1:1): Requires staff to be within arm's length to the patient at all times; One to One Behavioral (1:1) requires staff to watch the patient at all times while about 5 feet away for safety; and Line of Sight (LOS): Requires staff to see the patient at all times." c. The policy and procedure titled, "Patient and Environmental Safety Rounds" (Nursing Standard: Procedure 204; Revised June 2014) showed that staff were to observe all areas of the	A 144		

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A 144	Continued From page 21 ward accessible to patients. Staff were to assess for environmental and physical hazards that may contribute to an unsafe or unhealthy patient environment. d. The hospital policy titled, "Searches" (Policy 13.06; Effective Date: April 5, 2017) read: "Policy: "WSH (Western State Hospital) has a responsibility to provide for the safety and protection of patients, staff, visitors and the community, as well as providing a safe environment under which hospital staff may conduct searches. ...F. All staff members are required to continuously observe the environments for contraband [prohibited items], restricted items, safety hazards and potential weapons ...H. When searches may be warranted ...4. Previous behavior concerning contraband or restricted items." e. On 05/12/17 at 12:00 PM, a nurse manager (Staff Member #K3) provided Surveyor #9 with a copy of the staff guide for sharps and flex pens from the Center for Forensic Services procedure manual (no title, no date). The document read: "Flex pens are available at all times for your personal use on the ward and in the TRC. Staff must approve the use of any other drawing materials and if approved, they must be checked out and in at the end of the shift. Patients who misuse or modify flex pens may be required to use pens under supervision. No pens or pencils are allowed on the ward or in the TRC without supervision. 2. Staff interviews and review of the medical records of patients housed on F1 in the Center for Forensic Services showed the following: a. On 05/10/17 at approximately 10:45 AM,	A 144		

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A 144	Continued From page 22 Surveyor #9 reviewed the medical record of Patient #K4. The review showed that the patient had an extensive history of assaultive behavior and was a danger to others. 1) Documentation in the patient's record showed that on 04/05/17 the patient attempted to assault staff with a sharpened toothbrush. Review of environmental safety round documentation dated 4/5/2017 showed unit staff members had found no additional harmful objects in the patient's room after the assault. 2) Documentation dated 04/06/17 on the patient's treatment plan showed that the patient had a history of assaultive behavior without warning or provocation, and that he had assaulted another hospital staff member in August 2015 with a sharpened toothbrush. 3) At the time of the record review, Surveyor #9 discussed the findings with the unit's nurse manager (Staff Member #K3). Staff Member #K3 verified that no interventions had been implemented to prevent the patient from making weapons when the patient was admitted on 3/16/2017. b. On 05/12/17 at 10:30 AM, Surveyor #7 reviewed the medical record of Patient #K12 who was admitted on 4/7/2017. The admission psychiatric evaluation dated 4/7/2017 and nursing admission history showed that the patient had a history of engaging in self harming behaviors including swallowing foreign objects. 1) On 04/07/17, physician admission orders were written for 1 to 1 line of sight monitoring at all times secondary to swallowing foreign objects. On 4/17/2017, specialized monitoring (1 to 1 line	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 144	Continued From page 23	A 144		

of sight monitoring) was discontinued. On 5/2/2017, the patient was transferred to local acute care hospital after self-reporting ingestion of a flex pen and a "spork" (a plastic eating utensil that combines the attributes of a spoon and a fork).

2) On 05/03/17, the patient was transferred back and placed on 1 to 1 Close Suicide Watch monitoring. On 05/11/17 at 11:00 AM, physician orders were written to "Continue close monitoring for DTS" (danger to self). The behavior observational record dated 5/11/17 for the evening shift showed that the patient was on Close Suicide Watch due to his history of swallowing foreign objects and included a summary of behaviors to watch for. The evening assignment of patient care sheet for 5/11/2017 confirmed that Patient #K12 was on close suicide watch.

3) The evening/night shift nursing unit inter-shift report for 05/11/17 indicated that patient reported to staff that he had swallowed one pen, one spoon, and one toothbrush and was now complaining of abdominal plan. The patient was sent to a local acute care hospital for treatment.

c. On 05/12/17, at 11:35 AM, Surveyor #9 reviewed the medical record for Patient #K13. The record showed that the patient had a history of assaultive behavior and of obtaining and hiding contraband. The patient's treatment plan dated 4/25/2017 indicated that staff found two batteries hidden in the patient's sock and crayons in the patient's room.

1) On 05/09/17 beginning at 10:30 PM, entries in the patient's record showed that the patient had swallowed a spoon. The patient was sent to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 144	Continued From page 24 local acute care hospital for treatment. 2) At the time of the review, the nurse manager (Staff Member #K3) told Surveyor #9 that prior to the event on 05/09/17 Patient #K13 was not on any kind of special watch or monitoring for contraband or ingesting foreign objects. Staff Member #K3 stated that patients do not have to return sporks, toothbrushes and flex pens until after an adverse event occurs, even if they have a history of ingesting foreign objects. 3. Observations in the Center for Forensic Services unit showed the following: a. On 05/10/17 at 3:40 PM, during an inspection of clinical unit F6, Surveyor #7 observed two flex pens lying on the floor between rooms 19 and 24. This observation occurred after the on-coming staff had completed their environmental checks. b. On 05/12/17 at 11:30 AM on unit F1, Surveyor #1 observed a Patient Safety Assistant (PSA) (Staff Member #A1) during a 15-minute patient safety/environmental round check. While making the rounds with the PSA, Surveyor #1 found an external cover of a flex pen wrapped in plastic stored behind a book on the window seal that the PSA had missed. Surveyor #1 asked what happens when something is found. The PSA stated that he notifies the nurse; the nurse notifies security, security takes a picture of the item, and then the item is confiscated. The surveyor asked the nurse on duty (Staff Member #A2) if any additional actions were to be taken to find the missing inside mechanism of the pen. The nurse stated, "No". Unit staff members did not follow the policy and procedure for conducting environmental safety rounds as required.	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 25 c. On 05/12/17 at 11:58 AM, Surveyor #7 interviewed an institutional counselor (Staff Member #K10) on unit F1 about how environmental safety rounds are conducted. Staff Member #K10 indicated they occur primarily during shift change. She acknowledged that it was common to find flex pens on the floor during environmental and patient census rounds. d. 05/12/17 at 12:15 PM on unit F1, Surveyor #1 observed Patient #A1 hiding an item underneath their clothing. The surveyor brought it to the attention of the Ward Administrator (Staff Member #A3) who then asked a registered nurse (Staff Member #A4) to remove the item. The nurse confiscated five slices of bread from the patient. The nurse identified the patient as being extremely dangerous and was on 1:1 monitoring status at the time of the observation. Staff Member #A4 indicated that the patient should have been observed at all times by the assigned staff member to prevent such an occurrence. Unit staff members did not follow the specialized staffing policy and procedure. Item #3 - Contraband (Prohibited Items) Based on observation, interview and review of hospital policies and procedures, the hospital failed to develop effective processes to protect patients from contraband brought into the facility by visitors. Failure to develop and implement effective protocols that prevent visitors from bringing prohibited items into the facility risks harm to patients, staff members, and other visitors. Findings included:	A 144	**Plan of Correction for each specific deficiency cited:** (A 144) #3 The hospital failed to implement effective protocols that prevent visitors from bringing prohibited items into the facility that risks harm to patients, staff members, and other visitors. To ensure patients receive care in a safe setting the following corrections will be made: • WSH Immediate Clinical Safety Measure (ICSM) Management Bulletin MB17-06 was issued and included the following elements: 1. Staff will obtain a photocopy of picture identification and place in the Visitor Log under the photo identification tab. 2. Visitor will sign a Civil Visitation Statement of Understanding which includes specific parameters for visitation,	

identified contraband items, and behavioral expectations.

3. Visitor will sign the Oath of Confidentiality.
4. Staff will ensure the visitor signs the Visitor Log at the beginning and end of the visit.
5. The name on the photo identification will match the name on the Visitor Log and Statement of Understanding.

- If contraband is found a Security Incident Report (SIR) will be generated.
- WSH Policy 12.05 Patients Visitors has been updated.

Procedure/process for implementing the plan of correction:

- The updated policy 12.05 Patient Visitors was posted to the hospital's Electronic Policy Manual for all staff to access.
- Ward Administrators received an updated WSH policy 12.05 Patient Visitors.
- Ward Administrators were trained on the new visitor process on civil wards.
- New forms were placed in the ward Visitor Logs.

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

- Ward Administrators will audit the Visitor Log book and other visitor documentation to ensure compliance with ICSM 17-06 weekly until there are no deficiencies for two months and then monthly thereafter**.** Deficiencies will be referred to the center director for action
- Chief of Safety and Security will audit 100% SIRs identifying contraband monthly.

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

- The Chief Clinical Officer will include data regarding prohibited items brought into the facility that risk harm to patients, staff members, and other visitors and actions taken in the report to Patient Care Quality Council and the Governing Body quarterly.

Individual Responsible:

- Chief Clinical Officer

Date completed:

- January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 144	Continued From page 26 1. The hospital's policy titled "Patient Visitation"- (Policy #12.05, Effective 11/11) read: "#6. Visitors may not bring prohibited items into the hospital. Prohibited items include illegal items and patients are prohibited to have in their possession, including, but not limited to, the following: a. Any medication ...b. Intoxicating substances...c. Controlled drugs or illegal drugs . "All visitors must show photo ID [identification] ... 6 ...Visitors must sign in and out on the log." 2. On 5/12/17 at 9:15 AM, Surveyor #8 reviewed the medical record and visitor log for Patient #CS15 on Ward C8. The medical record showed that the patient had three visitors on 05/11/17. Only two of the visitor's log names were on the log. Additionally, the log failed to show evidence that the visitors presented photo ID to hospital staff members. None of the visitors documented their time in or out. 3. On 05/12/17 at 9:30 AM during an interview with Surveyor #8, the Nurse Manager (Staff Member #CS8) stated that shortly after the two visitors left Patient #CS15 on 05/11/17, the patient was slurring his words, appeared pale and gray in color, and had "pin-point" (constricted) pupils. Staff members searched the patient's room and found three liquid-filled syringes and one empty syringe. Hospital staff members determined the syringes contained heroin. This was confirmed by the patient. 4. On 05/24/17 at 9:15 AM, Surveyor #2 examined visitor logs on Ward S7. The form titled "Visitor's Register" had one entry dated 5/20/2017. The section titled "Time Out" did not have a time recorded per policy. The Ward Administrator (Staff Member #TH21) confirmed	A 144		

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A 144	Continued From page 27 the finding.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT- The patient has the right to be free from all forms of abuse or harassment. This Standard is not met as evidenced by: . Based on observation, interview, and review of hospital documents, policies, and procedures, the hospital failed to develop and implement effective policies, procedures, and interventions to protect patients from harm due to patient-to- patient assaults, as demonstrated by six patients reviewed (Patients #KM12, #KM16, #KM17, #KM18, #JW4, #JW5) Failure to ensure effective processes are in place to protect patients from abuse and harassment risks serious harm to patients due to physical and psychological injury. Findings included: 1. Review of the hospital policy titled "Specialized Staffing" (Policy 8.03; Issued 3/17) showed the following: a. Specialized staffing is allowed for "Danger to Others" (DTO), "Danger to Self "(DTS), and "Unpredictable Behavior" (UPB). One staff member per patient (1:1) or two staff members per patient (2:1) coverage is ordered by a physician when monitoring is needed to keep the patient from engaging in dangerous behaviors toward others. b. Specialized staffing includes the following	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 145	Continued From page 28 staffing ratios and monitoring parameters: One to One (1:1): Requires staff to be within arm's length to the patient at all times; One to One Behavioral (1:1) requires staff to watch the patient at all times while about 5 feet away for safety; and Line of Sight (LOS): Requires staff to see the patient at all times c. The physician's order for specialized staffing must state the specific action needed by the monitoring staff to keep patients safe (e.g., patient must be within arm's reach; 1:1 only during mealtimes; LOS (Line of Sight) at all times, etc. 2. Review of the hospital's policy and procedure titled "Management of the patient exhibiting potential for suicide (Suicide Watch)" (Standard Protocol 305, Revised April 2016) showed that when a patient required "Close" suicide watch, the RN was to assign a staff member to maintain view of the patient by direct visual observation at all times. 3. Review of the medical records for Patient #KM12 showed the following: a. The records included "Physician/Pharmacy" notes dated 04/10/17 at 7:15 PM that showed the patient had been in seven different physical altercations with other patients during the previous two weeks. Treatment and recovery plan addendums dated 04/04/17, and 04/08/17 included interventions for patient education, reorientation and medication administration to decrease agitation and aggression. b. On 05/04/17, Patient #KM12 assaulted two patients (Patients #KM17 and #KM23). On 05/09/17, Patient #KM12 assaulted another	A 145	**Plan of Correction for each specific deficiency cited:** (A 145) #1-10 The hospital failed to develop and implement effective policies, procedures and interventions to protect patients from harm due to patient-to-patient assaults. To ensure the hospital promotes patients' rights to be free from all forms of abuse or harassment the following corrections will be made: • #1-3: WSH Policy 8.01, Treatment Planning was updated to include the treatment team must review the treatment plan after each assault.	

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A 145	Continued From page 29 patient. The record did not contain physician orders for additional interventions to prevent the patient from assaulting other patients. 4. On 05/15/17 at 11:00 AM, Surveyor #9 observed 1:1 monitoring for Patient #KM17. The staff member assigned to monitor Patient #KM17 (Staff Member #KM8) was located approximately 25 feet from the patient. At the time of the observation, Staff Member #KM8 told Surveyor #9 that line of sight monitoring meant staff should be able to visibly see the patient. At 11:25 AM a registered nurse working in the unit (Staff Member #KM3) told the Surveyor #9 that line of sight monitoring meant staff should be close enough to intervene. 5. Review of the medical records for Patient #KM17 showed documentation of a pattern of unprovoked assaultive behavior on staff and other patients. a. On 03/10/17, Patient KM#17 tore an exit sign off the wall and assaulted staff member. On 05/09/17, Patient KM#17 tore a metal table leg off a table located in the patient's room and threatened staff which resulted in a lock down of the ward. The police were called and the patient was arrested. b. On 05/10/17, Patient KM#17 was readmitted to the hospital. The patient treatment and recovery plan and physician orders showed the patient was placed on 1:1 for DTO/DTS ("Danger to Others" and "Danger to Self") at all times for safety. On 05/12/17, a new physician order showed the patient was placed on 1:1 "Line of Sight" observation.	A 145	• #4: WSH Policy 8.03, Specialized Staffing was updated on May 12, 2017 to include the physician order must include the distance from the patient. • Staff will be trained on the different types of monitoring orders and what they mean. • #5: Treatment Teams will note patterns of assaultive behavior of patients and address the pattern in the treatment plan. • #6: Staff will receive refresher training on monitoring and keeping patient's safe while on close suicide watch. • #7-8: Distribution of ICSM Management Bulletin 17-07 to physicians regarding 1. Treatment plan addendums and the need for treatment plan addendums to match specialized staffing order. • #9-10: WSH Policy 8.03, Specialized Staffing was updated to include the physician order must specify distance the staff must be from the patient.	

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A 145	Continued From page 30 c. On 05/13/17, while on 1:1 line of sight monitoring, Patient KM#17 committed an unprovoked assault of another patient. 6. Review of the medical records for Patient #KM18 showed that physician orders were written on 05/13/17 for "Close" suicide watch. On 05/14/17 at 3:55 PM while on "Close" suicide watch, Patient KM#18 was assaulted by another patient (Patient KM#16) who had a pattern of assaultive behavior. 7. Review of the medical records for Patient #KM16 showed the patient had a pattern of unpredictable, unprovoked, and aggressive assaults of staff and other patients. Treatment and recovery plan addendums for staff and patient assaults were initiated on 01/16/17, 02/12/17, 03/02/17, 03/11/17, 04/04/17, 05/10/17 and 05/17/17. Physician orders for 1:1 DTO (Danger to Others) monitoring or WOOR (While out of Room) 1:1 monitoring were dated 02/07/17, 02/15/17, 03/10/17, 03/13/17, 03/16/17, 03/20/17, and 04/04/17. No physician orders for 1:1 monitoring for behavioral or assaultive behavior were located in the chart after 04/04/2017. On 05/14/17 at 3:55 PM, Patient KM#16 assaulted another patient (Patient KM#18). On 05/17/17 at 6:40 PM, Patient KM#16 again assaulted another (Patient KM#20). 8. On 05/18/17 at 2:00 PM, Surveyor #9 interviewed a psychiatrist (Staff Member KM#9) regarding Patient KM#16 and the assaults that occurred on 05/14/17 and 05/17/17. The surveyor asked about the lack of physician-ordered assault prevention interventions. The psychiatrist stated that Patient KM#16 was fully competent and these acts were fully volitional. The psychiatrist	A 145	**Procedure/process for implementing the plan of correction:** • #3: WSH Policy 8.01, Treatment Planning was updated to include the treatment team must review the treatment plan after each assault. • #4: WSH Policy 8.03, Specialized Staffing was updated to include the physician order must include the distance from the patient. • Staff will be trained on the different types of monitoring orders and what they mean. • #5: WSH Policy 8.01, Treatment Planning will be updated to ensure that Treatment Teams note patterns in assaultive behavior of patient to staff and other patients and will ensure this is an area of focus in the treatment plan. • #6: Organizational Development will develop refresher training for staff on monitoring and keeping patients safe while on close suicide watch. • #7,8,9: Distribution of Memo to physicians regarding: 1. Need for treatment plan addendums to match specialized staffing order. 2. Need for clarity of physician's orders related to specialized staffing. • Medical Staff Meeting will include discussion of memo regarding #7, 8 and 9 • #10: WSH Policy 8.03, Specialized Staffing was updated to include the physician order must specify distance the staff must be from the patient. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Quality Department will audit 10% of patient's charts that show repeated assaultive patterns monthly. The audit will include review for updated treatment plans or addendums addressing assaultive patterns, interventions for assaultive behaviors, and physician orders specifying distance. The Quality Department will	

			monitor until 90% compliance is achieved for two consecutive quarters. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Quality Department will analyze audit results, data and actions taken. The Quality Department will present data and recommendations in their report to Patient Care Quality Council and Governing Body on a quarterly basis. Patient Care Quality Council will make a decision regarding the recommendations made. **Individual Responsible:** • Chief Medical Officer **Date completed:** • January 15, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A 145	Continued From page 31 stated that it did not make a difference if the patient was on 1:1 staffing or not. 9. Review of the medical records of Patient #JW4 showed the following: a. Documentation in the patient's medical records showed that on 04/25/17 the patient was placed in restraints and seclusion (R/S) following assaults of another patient and a staff member. Following release from R/S the patient was placed on 1:1 DTO monitoring by a nursing order. b. On 04/28/17, Patient #JW4 assaulted another patient and was placed in seclusion. c. On 05/06/17, the on-call psychiatrist (Staff Member #JW10) documented that Patient #JW4 had assaulted another patient. The psychiatrist wrote, "Patient is on one to one monitoring, 2:1 monitoring was relaxed to 1:1 on 05/05/17. Patient also assaulted staff today. Plan... Start 2:1." d. On 05/08/17, the psychiatrist (Staff Member #JW5) wrote orders for Patient #JW4 to remain on 2:1 when the patient was out of his room for DTO (Danger to Others). The psychiatrist wrote in the patient's progress notes, "This patient must remain under close supervision to reduce his DTO. However, this patient does not belong to this milieu any longer. He should be removed to another setting where his criminal behavior can be addressed." e. On 05/11/17, Patient #JW4 assaulted two other patients and was subsequently transferred to a forensics ward. The psychiatrist orders did not specify distance the staff monitor was to maintain from the patient on the new ward.	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 145	Continued From page 32 f. 10. Review of the medical records for Patient #JW5 and an interview with a hospital staff member showed the following: a. The patient was in and out of R/S four times from 05/01/17 to 05/04/17 due to aggression toward staff, delusion, and threats of self-harm. b. On 05/07/17, a psychiatrist (Staff Member #JW12) wrote an order to continue to monitor for DTO/DTS (Danger to Self) for 24 hours. c. On 05/08/17, the patient was placed into seclusion due to an altercation with another patient. The psychiatrist (Staff Member #JW13) wrote an order for 2:1 monitoring for 72 hours. The patient remained on 2:1 monitoring until he attempted to strike another patient on 05/15/17 and was placed in restraints. The psychiatrist orders did not specify the distance the staff monitor was to maintain from Patient JW#13.	A 145		
A 146	482.13(d) PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS- Patient Rights: Confidentiality of Records This Standard is not met as evidenced by: Based on observation and interview, the hospital failed to store medical records in a secure location that was not subject to unauthorized access. Failure to safeguard patient records violated patients' rights to privacy and confidentiality of records.	A 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 146	Continued From page 33 Findings included: On 05/11/17 at 11:40 AM, during a tour of Ward S9 with the S9 Ward Administrator (Staff Member #RM1) and the Ward Clerk (Staff Member #RM2), Surveyor #4 observed some loose patient records and a 4-inch binder notebook containing several patients' medical records lying on a shelf in room #430. Staff RM-1 explained that the medication room (room #430) was not currently being used by staff due to an in-progress heating ventilation and air conditioning (HVAC) project. The staff member also stated that the construction contractors had access to room #430 during the course of the project. Staff Member #RM2 immediately collected the patient records and said she would remove them to a secure location.	A 146	**Plan of Correction for each specific deficiency cited:** (A 146) The hospital failed to safeguard patient records, violated patient's right to privacy and confidentiality. The hospital will ensure patient's rights to confidentiality and the following corrections will be made: • A patient discharge log will be implemented on each ward to ensure the confidentiality of patient discharge records. • The ward Office Assistants will ensure the medical record is transferred and received to Health Information Management Services (HIMS) within seven days; unless the discharged patient is known to be returning to the ward. • After each ward move, the Ward Administrator will return to the vacated ward and conduct a walk through to ensure all patient records have been moved to the new ward or sent to HIMS, as appropriate. • HIMS Director posted a reminder of HIPAA requirements on the EBB. **Procedure/process for implementing the plan of correction:** • A patient discharge log will be implemented on each ward to ensure the confidentiality of patient discharge records. • The ward Office Assistants will ensure the medical record is transferred and received by HIMS within seven days; unless the discharged patient is known to be returning to the ward. • After each ward move, the Ward Administrator will return to the vacated ward and conduct a walk-through to ensure all patient records have been moved to the new ward or sent to HIMS, as appropriate. • HIMS Director posted a reminder of HIPAA requirements on the EBB.	

			Monitoring and tracking procedures to ensure the plan of correction is effective: • The Ward Administrators will conduct weekly audits of the discharge logs for 30 days or until 100% compliance is achieved. • The Ward Administrator will verify walk-through has been completed by sending an email to the Center Director, stating that the vacant ward has been rounded and all medical records are off the vacated ward. If a medical record(s) is found, the Ward Administrator will immediately take the medical record to the ward or HIMS as appropriate. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Center Directors will report on deficiencies of confidentiality of patient records, and actions taken, during ward moves in their quarterly report to Patient Care Quality Council and the Governing Body until 100% compliance is achieved. **Individual Responsible:** • Center Directors **Date completed** • October 31, 2017	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION- Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This Standard is not met as evidenced by: Based on record review and review of hospital policies, procedures and documents, the hospital failed to ensure that patients were removed from seclusion or restraint at the earliest possible time for 7 of 10 patients reviewed (Patient #K1, #K2, #K3, #K4, #K5, #K6, #K7). Failure to remove patients from seclusion or restraint at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and	A 174	See Tag A 115	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 174	Continued From page 34 personal freedom. Findings included: 1. Review of hospital policies, procedures, and documents showed the following: a. The hospital policy and procedure titled "Management of the Patient in Seclusion and Restraint", (Standard Protocol 302; Revised January 2017) read: "Release from seclusion or restraint when behavior that necessitated seclusion or restraint is no longer in evidence and the release criteria stated in MD order is attained." b. The Behavioral Health Administration Inter-Hospital Policy titled "Seclusion and Restraint" (Policy No. 1.7; Effective January 30, 2017) states in part: "Seclusion and/or restraint will be discontinued as soon as safely possible at the earliest possible time, regardless of the scheduled expiration of the order. E.g. as soon as the imminent risk to self or others is no longer present or the patient's need can be addressed using less restrictive measures." c. The seclusion/restraint monitoring flowsheet (WSH 23-116Bb; Revised 03/17) under observable behavior(s) directs staff to "Notify RN when release criteria are met, or if patient is quiet/sleeping more than one 15 minute segment." 2. On 05/08/17 at 9:00 AM, Surveyor #7 reviewed the medical record of Patient #K1 who was placed in restraints on 05/07/17 at 5:30 PM after assaulting another patient. Patient #K1 was released from restraints on 05/08/17 at 9:00 AM, a period of 15.5 hours. Surveyor #7 noted the	A 174		

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A 174	Continued From page 35 patient's observed documented behavior of "mute/unresponsive" or "quiet/appears asleep" for the following periods: a. From 05/07/17 at 7:00 PM until 7:45 PM, a period of 45 minutes. b. From 05/08/17 at 12:45 AM until 3:00 AM, a period of 2 hours and 15 minutes. 3. On 05/10/17 while on clinical unit F1, Surveyor #7 reviewed the medical record of Patient #K2 who was placed in seclusion on 04/12/17 at 12:30 PM after assaulting another patient. Patient #K2 was released from seclusion on 4/14/2017 at 4:30 AM, a period of 36 hours. Surveyor #7 noted the patient's observed documented behavior was described as "unwilling to communicate with staff", sitting on the bed, "asleep", or "resting on bed", sitting at desk or reading/writing" and continued in seclusion for the following periods: a. From 04/12/17 at 6:00 PM until 6:45 PM, a period of 45 minutes. b. From 04/12/17 at 7:30 PM until 10:15 PM, a period of 2 hours and 45 minutes. c. From 04/12/17 at 10:45 PM until 4/13/2017 at 2:45 AM, a period of 4 hours. d. From 04/13/17 at 3:00 AM until 4:45 AM, a period of 1 hour and 45 minutes. e. From 04/13/17 at 6:00 AM until 10:45 AM, a period of 4 hours and 45 minutes. f. From 4/13/2017 at 1:15 PM until 5:00 PM, a period of 3 hours and 45 minutes.	A 174		

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A 174	Continued From page 36 g. From 04/13/17 at 7:15 PM until 4/14/2017 at 12:45 AM, a period of 5 hours and 30 minutes. h. From 04/14/17 at 3:00 AM until 4:30 AM, a period of 1 hour and 30 minutes. 4. On 05/10/17, at 9:10 AM, Surveyor #9 reviewed the medical record of Patient #K3, who was ordered into seclusion on five separate occasions between 4/26/2017 and 5/9/2017. The documentation on the seclusion/restraint monitoring flowsheet indicated the patient was "calm", "quiet" or "sleeping" and continued in seclusion for the following periods: a. From 04/27/17 at 1:15 AM to 7:30 AM, a period of five hours and 15 minutes. b. From 05/09/17 at 8:30 PM until 9:30 PM, a period of 1 hour. 5. On 05/10/17, at 10:45 AM, Surveyor #9 reviewed the medical record of Patient #K4, who was placed in seclusion on 04/06/17 at 7:40 AM and released from seclusion on 04/07/17 at 5:30 AM. The documentation on the seclusion/restraint monitoring flowsheet indicated the patient was resting, quiet or sleeping and continued in seclusion for the following periods: a. From 04/06/17 at 10:15 AM to 11:30 AM, a period of 1 hour and 15 minutes. b. From 04/07/17 at 1:45 AM to 5:00 AM, a period of 3 hours and 15 minutes. 6. During record review, Surveyor #6 reviewed 4 medical records of patients who were placed in restraints and noted the following:	A 174		

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A 174	Continued From page 37 a. Patient #K5 was restrained on 04/18/17 from 11:05 AM until 12:12 PM, a period of 1 hour and 7 minutes. No documentation of the patient's behavior was recorded for the first 45 minutes of the restraint episode. The remaining 22 minutes of the restraint period was described as "sleeping on and off". b. Patient #K6 was restrained on 04/13/17 from 4:45 PM to 6:45 PM, a period of 2 hours. The patient's behavior was documented as "mute/unresponsive" from 5:30 PM to 6:30 PM and "Quiet/Appears Asleep" at 6:45 PM. c. Patient #K7 was restrained on 04/16/17 from 9:30 PM to 04/17/17 at 1:00 AM. Documentation indicates the patient was "Mute/Unresponsive" and/or "Quiet/Appears Asleep" between 10:00 PM and 1:00 AM, a period of 3 hours.	A 174		
A 175	482.13(e)(10) PATIENT RIGHTS: RESTRAINT OR SECLUSION- The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This Standard is not met as evidenced by: Based on record reviews, interviews, and review of hospital policies, procedures, and documents, the hospital failed to ensure hospital staff monitored patients placed in seclusion or restraints according to hospital policy for 9 of 10 patients reviewed (Patients #K1, #K3, #K4, #K5, #K6, #K7, K9, #K10, #K11).	A 175	See Tag A 115	

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A 175	Continued From page 38 Failure to monitor patients who are restrained or secluded puts them at risk for injury or decline in status. Findings included: 1. Review of hospital policies, procedures, and documents showed the following: a. The hospital policy and procedure titled "Management of the Patient in Seclusion and Restraint", (Standard Protocol 302; Revised January 2017) states in part, "E. Monitor physical, emotional and safety needs... RN assigns staff member to engage patient, perform care and need interventions, and document behavior response to seclusion or restraints at least every 15 minutes. ...Check breathing...skin color, circulation...Proper positioning of restraint devices(s) to prevent restriction of circulation...Assess circulation, reposition and perform ROM at least every two hours." b. The seclusion/restraint monitoring flowsheet (WSH 23-116Bb; PILOT Revised 03/17) under observable behavior(s) directs staff to "Check the appropriate Observable Behavior box every 15 minutes and initial at the bottom." 2. On 05/08/17 at 9:00 AM, Surveyor #7 reviewed the medical record of Patient #K1 who was placed in restraints on 5/7/2017 at 5:30 PM and was released from restraints on 5/8/2017 at 9:00 AM, a period of 15.5 hours. There was no documentation on the seclusion/restraint flowsheet to indicate that staff members assessed the patient's circulation or checked for "Signs of Injury/Skin Integrity" for the following periods:	A 175		

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A 175	Continued From page 39 a. From 05/07/17 at 5:30 PM until 9:00 PM, a period of 3 hours and 30 minutes. b. From 05/07/17 at 9:15 PM until 10:15 PM, a period of 1 hour. c. From 05/08/17 at 3:15 AM until 5:00 AM, a period of 1 hour and 45 minutes. d. From 05/08/17 at 7:30 AM until released at 9:00 AM, a period of 1 hour and 30 minutes. 3. On 05/09/17 at 1:30 PM, Surveyor #7 reviewed the medical record of Patient #K9 who was placed in 5 point restraints on 5/8/2017 at 10:40 AM and was released from restraints on 5/10/2017 at 1:30 PM, a period of 49.5 hours. There was no documentation on the seclusion/restraint flowsheet to indicate that staff members assessed the patient's circulation or checked for "Signs of Injury/Skin Integrity" for the following periods: a. From 05/08/17 at 1:00 PM until 7:30 PM, a period of 6 hours and 30 minutes. b. From 05/08/17 at 9:15 PM until 10:15 PM, a period of 1 hour. c. From 05/09/17 at 4:45 AM until 5:30 AM, a period of 45 minutes. d. From 05/09/17 at 10:00 AM until 11:30 AM, a period of 1 hour and 30 minutes. e. From 05/09/17 at 3:30 PM until 7:30 PM, a period of 4 hours. f. From 05/09/17 at 9:00 PM until 05/20/17 at 12:45 AM, a period of 3 hours and 45 minutes.	A 175		

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A 175	Continued From page 40 g. From 05/10/17 at 2:45 AM until 3:30 AM, a period of 45 minutes. 4. During record review, Surveyor #6 reviewed 4 medical records of patients who were placed in restraints and noted the following: a. Patient #K5 was restrained on 04/18/17 from 11:05 AM until 12:12 PM, a period of 1 hour and 7 minutes. No documentation of circulation checks or checks for injury/skin integrity were recorded from 11:05 AM to 12:05, a period of 1 hour. b. Patient #K6 was restrained on 04/13/17 from 4:45 PM to 6:45 PM, a period of 2 hours. No documentation of checks for signs of injury/skin integrity, offering food/fluids, or psychological or physical comfort from 4:45 PM to 6:45 PM were recorded, a period of 2 hours. c. Patient #K7 was restrained on 04/16/17 from 9:30 PM to 04/17/17 at 1:00 AM. No documentation of checks for injury/skin integrity from 9:30 PM to 1:00 AM were recorded, a period of 3 hours and 30 minutes. The surveyor also found no checks for circulation from 9:30 PM to 10:30 PM, a period of 1 hour. d. Patient #K10 was restrained on 04/16/17 from 4:45 PM to 6:30 PM, a period of 1 hour and 45 minutes. No documentation of checks for signs of injury/skin integrity from 5:00 PM to 6:00 PM were recorded, a period of 1 hour. 5. On 05/10/17 at 9:10 AM, Surveyor #9 reviewed four episodes of seclusion being ordered for Patient #K3. The surveyor noted there was no documentation on the seclusion/restraint monitoring flowsheet to indicate that staff	A 175		

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A 175	Continued From page 41 members assessed the patient's circulation and respiration for the following periods: a. From 04/26/17 at 7:30 PM to 8:15 PM, a period of 45 minutes. b. From 04/26/17 at 9:45 PM then released from seclusion on 04/27/17 at 9:30 AM, a period of 11 hours and 45 minutes. c. From 05/03/17 at 7:45 PM to 11:45 PM, a period of 4 hours. d. From 05/04/17 at 1:00 AM to 2:15 AM, a period of 1 hour and 15 minutes. e. From 05/04/17 at 2:30 AM to 3:15 AM, a period of 45 minutes. f. From 05/04/17 at 4:00 AM to release on 5/4/2017 at 4:45 AM, a period of 45 minutes. g. From 05/04/17 at 9:50 AM through 4:45 PM, a period of 6 hours and 55 minutes. h. From 05/09/17 at 7:30 PM through 11:15 PM a period of 3 hours and 45 minutes. i. From 05/10/17 at 1:30 AM through 5/10/2017 4:30 AM, a period of 3 hours. 6. On 05/10/17 at 10:45 AM, Surveyor #9 reviewed the medical record of Patient #K4, who was placed in seclusion on 04/06/17 at 7:40 AM and released from seclusion on 04/07/17 at 5:30 AM. There was no documentation on the seclusion/restraint monitoring flowsheet to indicate that staff members assessed the patient's circulation and respiration for the following periods:	A 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 175	Continued From page 42 a. From 04/06/17 at 7:45 AM to 8:45 AM, a period of 1 hour. b. From 04/06/17 at 9:00 AM to 2:45 PM, a period of 5 hours and 45 minutes. c. From 04/06/17 at 5:15 PM until released from seclusion on 04/07/17 at 5:30 AM, a period of 12 hours and 15 minutes. 7. On 05/10/17 at 2:15 PM, Surveyor #9 reviewed four episodes of restraints being ordered for Patient #K11. The surveyor noted there was no documentation on the seclusion/restraint monitoring flowsheet to indicate that staff members assessed the patient's circulation and respiration for the following periods: a. From 04/28/17 at 3:40 PM then released from seclusion at 4:45 PM, a period of 1 hour and 5 minutes. b. From 05/02/17 at 10:40 AM then released from seclusion at 11:40 AM, a period of one hour. c. From 05/04/17 at 4:50 PM then released from seclusion at 5:50 PM, a period of one hour. d. From 05/05/17 at 3:45 PM then released from seclusion on 5/5/2017 at 5:45 PM, a period of 2 hours. 8. On 05/10/17 at 9:44 AM, Surveyor #9 interviewed a nurse manager (Staff Member #K3) about monitoring and recording on the seclusion/restraint flowsheet. Staff Member #K3 confirmed that 15 minute checks for circulation and respiration should have been completed on the flowsheet per hospital policy.	A 175		

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A 175	Continued From page 43 9. On 05/23/17 at 10:35 AM, Surveyors #7 and #9 interviewed the hospital restraint and seclusion training team (Staff Members #K4, #K5, #K6, #K7, #K8) about how patients are monitored in seclusion and restraints. Staff Member #4 indicated that breathing and circulation checks are to be performed and documented every 15 minutes on the seclusion/restraint monitoring flowsheet.	A 175		
A 263	482.21 QAPI- The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data	A 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 263	Continued From page 44 collection and analysis. Failure to systematically collect and analyze hospital-wide performance data limited the hospital's ability to identify problems and formulate action plans. This reduced the likelihood of sustained improvements in clinical care and patient outcomes. Findings included: 1. The hospital failed to develop and implement a QAPI program that measured meaningful quality indicators for all departments and services.	A 263	**Plan of Correction for each Specific deficiency cited** (A 263) The hospital failed to develop and implement a QAPI program that measured meaningful quality indicators for all departments and services. To ensure that the hospital's QAPI program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors the following corrections will be made: • QAPI plan will be updated to include a hospital-wide quality assessment and performance improvement process to monitor, evaluate, and improve the quality of patient care services, including systematic data collection and analysis. • The QAPI Program will include the requirement of all departments and services to have quality indicators that measure, monitor, and evaluate improvements in clinical care and patient outcomes. • See Tag A 700 • See Tag A 710 **Procedure/Process for Implementing the POC** • Updated QAPI plan to be approved by Patient Care Quality Council and Governing Body. • Provide education to all clinical staff regarding updates made to the QAPI plan. • QAPI plan posted to the WSH Intranet. • Meaningful quality performance Indicators will be selected. • Quality indicator data will be monitored, analyzed, and tracked for all departments and services. • Education on how to analyze meaningful quality data will be given to	

	Cross Reference: Tag A0273 2. The hospital failed to develop and implement an effective QAPI program that included systems for ensuring the patient care environment is free from safety hazards, including plans for implementing a fire watch due to an impaired fire suppression system. Cross Reference: Tags A0700, A0710 (Fire/Life Safety Statement of Deficiencies) Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.21, Quality Assurance and Performance Improvement was NOT MET.		department and service managers or designees responsible for the data collection, analysis and measurement. **Monitoring and tracking Procedures to ensure the POC is effective** • Data will be collected, tracked, monitored and analyzed to determine if goals are being met. • If goals are not met, then action items will be developed to improve patient outcomes. • Action items will be implemented and the hospital's quality indicators will be tracked through Patient Care Quality Council. • A reporting calendar/schedule will be created to track that each discipline is tracking, monitoring, analyzing (drill down) data, and taking action if needed. **Process Improvement: actions incorporated into its QAPI program** • Quality indicators, analyzed (drill down) data and actions taken will be incorporated into each department's quarterly report to Patient Care Quality Council & the quarterly report to Governing Body. • QAPI plan will be reviewed annually and updates made will be approved by Patient Care Quality Council and Governing Body. **Individual Responsible** • Chief Quality Officer **Date Completed** • June 30, 2018	
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS- (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ...	A 273	**Plan of Correction for each specific deficiency cited:** (A 273) The hospital failed to develop, implement, and maintain a hospital-wide, integrated Quality Assessment Performance Improvement (QAPI) program that included selection of meaningful quality indicators for all departments and services. The hospital will measure, analyze, and track quality indicators and other aspects of performance that assess processes of care, hospital service and operations. To ensure the QAPI program incorporates quality indicator data including patient care data, and other relevant data, the following corrections will be made: • The Hospital wide QAPI program will be updated to include the requirement of all departments and services to have quality indicators that measure, analyze, track and evaluate	

improvement in clinical care, patient outcomes and the effectiveness and safety of services provided.

- Quality indicators and/or the requirement of action plans to address goals not met will be specifically selected and developed for :

-Utilization Management including medical necessity of admissions, duration of hospital stays, discharge planning, and efficacy of professional services.

-Nutritional Services regarding the quality of services provided for patients.

-Physical Therapy, Dental Services and Radiological Services regarding the quality of services provided for patients.

-Referrals for Consultative Services regarding The quality of services provided for patients.

-Emergency Services regarding data on the response to medical emergencies and action plans for improvement.

-Pain Management regarding the quality of services provided.

-Infection Prevention and Control regarding hospital acquired infections and action plans will be developed to reduce incidents of infections.

-Active Treatment regarding quality of services provided and if treatment resulted in improved health outcomes.

-Patient Grievances regarding patient complaints, grievances, and timeliness of response to patients and action plans will be developed for addressing complaint issues.

- See A 1134, A 528, A 1123, A 049, A 652

Procedure/Process for Implementing the POC

- Updated QAPI program will be incorporated into the QAPI plan.
- Quality indicators will be selected for all departments and services.
- Updated QAPI plan and quality indicators will be approved by Patient Care Quality Council and Governing Body.
- Provide Education to Departments and Clinical Services regarding updates made to the QAPI plan.
- QAPI plan posted to the WSH Intranet.
- Education on how to analyze meaningful quality data and improvement plans will be given to department managers or designees

			responsible for the data collection, analysis and measurement. **Monitoring and tracking Procedures to ensure the POC is effective** • Quality indicator data will be monitored, analyzed, and tracked for all departments and services to determine if goals are being met. • If goals are not met, then process improvement plans will be developed to address the unmet goals and improve patient outcomes. • Action items from the improvement plans will be implemented and the hospital's quality indicators and improvements will be tracked through Patient Care Quality Council. • A reporting calendar/schedule will be created to track that each discipline is tracking, monitoring, analyzing (drill down) data, and taking action if needed. **Process Improvement: actions incorporated into its QAPI program** • Quality indicators, analyzed (drill down) data and actions taken will be incorporated into each department's and services' quarterly reports to Patient Care Quality Council and Governing Body. • QAPI plan and quality indicators will be reviewed annually and updates made will be approved by Patient Care Quality Council and Governing Body. **Individual Responsible** • Chief Quality Officer **Date Completed** • June 30, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 273	Continued From page 45 (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This Standard is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to develop, implement, and maintain a hospital-wide, integrated Quality Assessment Performance Improvement (QAPI) program that included selection of meaningful quality indicators for all departments and services. Failure to select meaningful quality indicators, to systematically collect and analyze performance data, and to formulate action plans for improvement reduces the likelihood of sustained improvements in clinical care and patient outcomes.	A 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 273	Continued From page 46 Findings included: 1. The hospital's quality program plan titled "Quality Assessment and Performance Improvement Plan 2016-2018" showed that the plan was to provide the hospital with mechanisms to identify opportunities for performance improvement and a process to improve identified deficiencies. The plan identified a collaborative hospital-wide approach for sustaining performance improvement in patient care outcomes and enhancement of the quality of the practice of the health care professionals who provide that care. The plan showed data collection was to focus on processes, outcomes, targeted areas of study, comprehensive performance measures, client's needs, expectation and feedback, results of ongoing infection control activities, safety of the environment, quality control and risk management findings, and dimensions of performance. 2. On 05/09/17 from 9:30 AM to 4:00 PM, Surveyor #6 interviewed the Chief of Quality (Staff Member #M4); the Quality Director (Staff Member #M5); the "Lean" Program Director (Staff Member #M6); the HIM Director (Staff Member #M7); and the Performance Improvement Manager (Staff Member #M8). During this interview, the meeting participants reviewed the hospital's QAPI plan, quality committee meeting minutes, quality indicators, and performance improvement plans and documents. During this interview and a subsequent interview with the Chief of Quality and the Deputy of Hospital Operations (Staff Member #M9) on 05/23/17 from 11:05 AM to 2:00 PM, Surveyor #6 determined the following:	A 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 273	Continued From page 47 a. Utilization Management (UM): Service managers reported numbers of patient records reviewed and certifications completed. UM managers did not aggregate and submit data regarding the quality of care provided as directed by the hospital's Utilization Management Plan (Effective October 2015), including medical necessity of admissions, duration of hospital stays, discharge planning, and efficacy of professional services . Cross Reference: Tag A0652 b. Nutritional Services: Service managers submitted quality control data including food temperatures. There were no indicators that measured the quality of nutritional services provided for patients. Cross Reference: Tag A0049, Item #2 c. Physical Therapy, Dental Services, Radiological Services: Service managers submitted data regarding the numbers of procedures performed. There were no indicators that measured the quality of services provided for patients. Cross Reference: Tags A0528, A1123 d. Referrals for consultative services: The QAPI program did not include quality indicators for patient referrals for consultative services such as nutritional services, physical therapy, wound care, and orthotic services. Cross Reference: Tag A1134 e. Emergency Services: Service managers	A 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 273	Continued From page 48 submitted data regarding response to medical emergencies. There were no action plans for improvement for problems identified during emergency response incidents. f. Pain Management: Service managers submitted data regarding the numbers of patients referred for palliative care and pain control services. There were no indicators that measured the quality of the services provided. g. Infection Prevention and Control: The infection preventionist submitted data regarding the numbers and types of hospital-associated infections. There were no action plans for reducing incidents of infections. h. Active Treatment: Service managers submitted the number of hours of psychiatric, psychological, and mental health treatment provided per patient. There were no indicators that measured the quality of the treatment provided and whether this treatment resulted in improved health outcomes. i. Patient Grievances: Service managers identified the numbers of patient complaints and grievances, the timeliness of response to patients, and types of complaints. There were no action plans that addressed complaint issues. .	A 273		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This Condition is not met as evidenced by: Based on interview, record review, and review of	A 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 385	Continued From page 49 hospital policies and procedures, the hospital failed to ensure that nursing staff members provided nursing care in accordance with the patient's health care needs. Failure to provide nursing care based on patient assessments and recommendations of health care consultants risk deterioration of the patient's health status and poor health care outcomes. Findings included: 1. The hospital failed to ensure that nursing staff developed and implemented care plans for patients at high risk for falls, 2. The hospital failed to ensure that nursing staff members developed and implemented care plans for patients with nutritional needs. 3. The hospital failed to ensure that hospital staff members had an effective system to communicate patient care recommendations made by health care consultants. Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.23, Nursing Services was NOT MET Cross Reference: A0396	A 385	See Tag A 396 #1 See Tag A 396 #2 See Tag A 396 #3	
A 396	482.23(b)(4) NURSING CARE PLAN- The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This Standard is not met as evidenced by:	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 50 Item #1- Fall Prevention Care Plan Based on interview and review of hospital policies and procedures, the hospital failed to ensure that staff developed and initiated care plans for patients at high risk for falls, as demonstrated by four patients reviewed (Patients #KM1, #KM2, #KM3, #KM4). Failure to identify patients who are at high risk for falls and develop care plans to prevent falls places patients at risk of injuries. Findings included: 1. The hospital's policy and procedure titled "Management of the Patient at Risk for Falls" (Revised March 2017) stated, "Area of Responsibility... D. Physical Therapy Referral if needed... 4. Refer for PT eval [Physical Therapy evaluation] if: A. High Fall Risk (Tinetti score 0-19). B. Pt. is non-ambulatory upon admit or with change of condition affecting ambulation... F. Interdisciplinary Management Interventions... 9. Consult with physical and occupational therapy to plan a program to increase patient's endurance and strength." 2. On 05/10/17 at 2:00 PM, Surveyor #9 reviewed the medical record for Patient #KM1, reviewed the nursing shift report, and interviewed a registered nurse (Staff Member #KM1). The review and interview showed the following: a. The Initial Nursing Assessment (Form WSH 23-60A) completed on 04/26/17, under subsection: "Safe patient handling and movement assessment" read: "...2. Patient Level of Assistance: Stand-by-assist. 3. Weight bearing capability: ...partial. ...5. Applicable conditions	A 396	**Plan of Correction for each specific deficiency cited** (A396) #1. The hospital failed to ensure the staff developed and initiated care plans for patients at high risk for falls. The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan is a part of an interdisciplinary care plan. • The medical record will include a treatment plan addendum that identifies the problem “High Risk for Fall”, goals and interventions. • The nursing inter-shift report will identify the patient as a high fall risk. • The treatment plan will identify patients that are at high risk for falls and interventions to prevent falls. • Non-ambulatory patients will be referred to the physician for assessment for physical therapy referral. **Procedure/process to implement the plan of correction:** • Nursing Standard 339 was updated to include specific notification to the physician for physical therapy referral, including the requirement that all non-ambulatory patients or patients that cannot be assessed using the Tinetti Scale (e.g., non-ambulatory, patient refusal, etc.) will be referred to the physician to assess for physical therapy referral. • Nursing Standard 339 requires a treatment plan/addendum to be completed for any patient who is identified by the RN to be at high risk for falls. • The Chief Nursing Officer communicated to all nursing staff that revised Nursing Standard 339 “Management of the Patient at Risk for Falls” must be reviewed and followed. • The Tinetti Test form will be updated to include the requirement for any patient at high risk for falls to have treatment	

plan interventions to help prevent falls.

- RNs are now identifying patients who have been identified as a high fall risk in inter-shift report.
- An electronic program change will be implemented to enable the registered nurse to identify high fall risk patients on the electronic inter-shift report that will remain there until high fall risk is discontinued.
- A consultation tracking system was developed to include a tracking spreadsheet for all physician ordered consultations to include patients identified as a high fall risk based on a Tinetti score of less than 20. This process tracks the timely initiation of the treatment plans based on consultation recommendations.

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

- RN3's will ensure treatment plans are updated to include patients at high risk for falls.
- Ward Administrators audit the consult tracking spreadsheet on every business day to ensure referrals have been made to physical therapy.
- If a referral has not been made the appropriate discipline will be notified by the Ward Administrator for immediate follow-up.
- Quality Coordinators will audit 10% of treatment plans for fall prevention strategies for patients identified as high risk for falls monthly.
- Quality Coordinators will provide feedback to Nurse Managers based on their findings to follow up on any identified issues.

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

- The Quality Department will provide audit result data for the fall prevention interventions to Nursing. The Nursing Department will present data analysis, actions taken, and recommendations in their report to Patient Care Quality Council and Governing Body on a quarterly basis. Patient Care Quality Council will make a decision regarding the recommendations made by the Nursing Department.

Individual Responsible:

- Chief Nursing Officer

Date Completed:

- March 31, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 51 likely to affect transfer/repositioning techniques ... paralysis/paresis 6. Assistive Devices ...Wheelchair". Under Subsection: "Tinetti Test (Fall Risk Index): Balance and Gait score 16". b. According to the Tinetti Fall Risk Index, a Tinetti Score of less than 20 means the patient is at high risk for falls. A physical therapy consult had not been initiated as directed by hospital policy. The medical record did not include a care plan or treatment plan addendum that identified the problem "High Risk for Fall", goals and interventions. c. The nursing report sheet did not identify Patient #KM1 as a high fall risk. d. Staff member #KM1 confirmed the findings above and stated, "If a patient is a high fall risk it should be on the report sheet." 3. On 05/16/17 at 10:00 AM, Surveyor #9 reviewed the medical records for Patient #KM3 and interviewed a registered nurse (Staff Member #KM2). The review and interview showed the following: a. The patient was admitted on 04/28/17 for treatment of competency restoration. The Initial Nursing Assessment Tinetti Score indicated the patient was not at risk for falls. On 05/03/17, Patient #KM3 experienced a seizure resulting in a fall to the floor. Physician/Pharmacy and Nursing Notes documentation showed Patient #KM3 exhibited additional seizure like activity that resulted in falls to the floor on 05/04/17, 05/06/17, 05/07/2017 and 05/09/17. No physical therapy consult was initiated. The medical record did not include a care plan or treatment plan addendum that identified the problem "High Risk for Falls."	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 396	Continued From page 52 Subsequent review of the patient's medical record on 5/16/207 at 9:30 AM revealed additional seizure activity resulting in a fall to the floor on 05/10/17. A treatment and recovery plan addendum identifying the patient as high Risk for Falls was not initiated until 05/12/17 at 3:50 PM. b. Surveyor #9 asked the nurse about the delay in adding "High Fall Risk" to the Patient Treatment and Recovery Plan. The nurse stated that she had not thought about performing a fall risk assessment until someone called her during the survey and told her to do one. 4. On 05/16/17 at 10:40 AM, Surveyor #9 reviewed the medical records for Patient #KM2, reviewed and nursing shift report, and interviewed a registered nurse (Staff Member #KM2). The review and interview showed the following: a. The Initial Nursing Assessment (Form WSH 23-60A) completed on 04/11/17 showed under subsection: "Safe patient handling and movement assessment: ...2. Patient Level of Assistance: Stand-by-assist; 3. Weight bearing capability: ...partial; ...5. Applicable conditions likely to affect transfer/repositioning techniques: ... severe osteoporosis; 6. Assistive Devices: ...Wheelchair; ...Staff assist with transfer'". Under subsection: "Tinetti Test (Fall Risk Index): Balance and Gait score 18". b. According to the Tinetti Fall Risk Index, a Tinetti Score of less than 20 means the patient is at high risk for falls. A physical therapy consult had not been initiated as directed by hospital policy. The medical record did not include a care plan or treatment plan addendum that identified the problem "High Risk for Falls"	A 396		

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 53 c. The nursing report sheet did not identify Patient #KM2 as a high fall risk. d. Staff Member #KM2 confirmed the above findings. 5. On 05/25/17 at approximately 12:20 PM, Surveyor #9 reviewed the medical records for Patient #KM4, reviewed the nursing shift report, and interviewed a registered nurse (Staff Member #KM1). The review and interview showed the following: a. The Initial Nursing Assessment (Form WSH 23-60A) completed on 05/22/17 read: "Safe patient handling and movement assessment: ...2. Patient Level of Assistance: Assistive devices should be used for some lifting and moving tasks; ...3. Weight bearing capability: ...none; 5. Applicable conditions likely to affect transfer/repositioning techniques: ...(No documentation); 6. Assistive Devices ...Wheelchair." Under "Tinetti Test (Fall Risk Index)" the balance and gait score was not completed as the patient was assessed as non-ambulatory. No fall risk assessment was completed. A physical therapy consult had not been initiated as directed by hospital policy. b. Documentation in the nursing notes stated: ""Pt [patient] displays severe memory deficit ....Pt wheelchair bound." The Admission History and Physical Examination (Form WSH 23-55C) completed on 05/23/17 read: "Admission Physical Exam... Decreased ROM (Range of Motion) LE (Lower Extremity)... amb [ambulates] stiffly with walking." Under Subsection: "Diagnosis/Plan... Uses walker/wheelchair to get around."	A 396		

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 54 c. The medical record did not include a care plan or treatment plan addendum that identified the problem "High Risk for Falls" nor goals and interventions to prevent falls. d. The nursing report sheet did not identify Patient #KM4 as a high fall risk. e. As the result of survey findings, a physician initiated a Rehabilitation Service Consultant Referral on 05/24/17. The referral read: "Current diagnosis or signs/symptoms to be treated: Multiple back surgery years ago has chronic back pain with difficulty to walk. In w.c. [wheelchair] now ...2. Patient functional limitations: Unable to ambulate, was using cane ...Patient prior level of functioning ...limited ambulation." f. During the interview the nurse stated that Patient #KM4 used a walker when he arrived to the unit, and that walkers were not allowed on the unit. The surveyor asked the nurse about how fall risk assessments are performed for patients who are immobile and not eligible for the Tinetti Assessment (Fall Risk Index). The nurse told the surveyor that the hospital had no other method for assessing fall risk. The nurse confirmed that a physical therapy evaluation of the patient had not been initiated on 05/22/17 as directed by hospital policy. Item #2 - Nutritional Care Plan Based on observation, interview, and record review, the hospital failed to ensure that nursing staff members developed and implemented care plans for patients with nutritional needs, as demonstrated by 5 patients reviewed (Patients	A 396	**Plan of Correction for each specific deficiency cited:** (A396) #2 The hospital failed to ensure that nursing staff members developed and implemented care plans for patients with nutritional needs. The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan is a part of the interdisciplinary care plan.	

Continued From page 55
#K8, #JW1, #JW2, #JW3, #M1).

Failure to identify patients with impaired nutrition and develop care plans to meet the patient's nutritional needs risks deterioration of the patient's health and prolonged hospitalization.

Findings included:

1. The hospital's policy and procedure titled "Vital Signs/Daily Care Flowsheet (Procedure #9.4; Revised 01/16) showed that when daily weights were ordered by a doctor or nurse, the patient's weight would be documented on a Vital Signs/Daily Care Flowsheet in the weight column on the line corresponding with the current date and time.

2. On 05/08/17 at 10:00 AM, Surveyor #10 reviewed the medical records of Patient #JW1 and interviewed the Ward Administrator for the patient's treatment unit (Staff #JW2). This record review and interview revealed the following:

a. The patient had a cerebrovascular accident (stroke) in October 2016. The patient developed a stage II pressure ulcer on the buttocks and was receiving ongoing wound care. On 02/01/17, the patient's physician (Staff Member #JW1) ordered the following nutritional supplements: Two cans of Ensure Plus four times a day and protein powder three times a day.

b. On 02/01/17, the physician ordered that the patient was to be weighed weekly. The first weight recorded on the vital sign/daily care flowsheet was dated 02/11/17. No weights were recorded between 02/11/17 and 03/02/17. On 03/02/17, the patient's physician (Staff Member #JW1) repeated the order for weekly weights.

Procedure/Process to implement the Plan of Correction:

(A 396) #2: Nutritional Care Plan

- The ward based nursing staff will receive education on documentation requirements for patient weights.
- Ward based nursing staff will document patient weights on the vital signs daily care flowsheet per standard and physician order.
- Supplemental nutrition will be documented on the Nursing Treatment Administration Records (TARs).
- If the patient refuses supplemental nutrition or weights, and demonstrates weight loss/gain of 5% of baseline weight within a month or 7.5% in three months or 10% in six months this will be reported to the Physician.
- A training plan will be developed to educate ward based RNs and LPNs on the elements needed to be included on the TAR.
- A training plan will be developed and implemented to educate ward based RNs and LPNs on Nursing Standard 334 “Management of the Patient with Weight Instability.”
- Any patients with nutritional needs (medical) will have their treatment plan/addendum updated.

Monitoring and tracking procedures:

- RN3’s will audit 10% of TARs monthly for documentation compliance for those patients on supplemental nutrition.
- RN3’s will audit 10% of vital signs daily care flowsheets monthly for documentation compliance for patient weights.
- Quality Coordinators will audit 10% of treatment plans/addendum monthly for nutritional needs.
- Quality Coordinators will provide feedback to Nurse Managers based on their findings to follow up regarding any identified issues.

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

- The Quality Department will provide audit results for patients with nutritional needs. The Nursing Department will present data analysis, actions taken and recommendations in their report to Patient Care Quality Council and Governing Body on a quarterly basis. Patient Care Quality Council will make a decision regarding the recommendations made.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 56 The next recorded weight was dated 03/12/17. There were no recorded weights or refusals to be weighed between 03/12/17 and 03/30/17. On 0/30/17, the physician repeated the order for weekly weights. Documentation in the patient's record indicated the patient refused to be weighed on 04/01/17. On 04/02/17, the patient's weight was recorded. No further weights were recorded until 04/29/17. c. During an interview with Surveyor #10 at the time of the record review, the Ward Administrator (Staff Member #JW2) confirmed that based on review of patient records, the patient had not been weighed daily as ordered. 3. On 05/08/17 at 1:40 PM, Surveyor #6 reviewed the medical record of Patient #M1 and interviewed a registered nurse who provided care in patient's treatment unit (Staff #M1). This record review and interview revealed the following: a. The patient had a neurodevelopmental and metabolic disorder that required a 6000 calorie per day diet. The patient had a gastrointestinal tube (a tube surgically inserted through the patient's abdominal wall into the patient's intestine) as an access for supplemental feeding. b. On 12/21/16, the patient's physician (Staff Member #M2) ordered the following dietary supplement: "Peptamen 1.5 - Give 1000 cc overnight through feeding tube; Run it at 125 cc/hr.". On 12/29/16, the physician ordered the following nutritional supplement: "Give Boost Plus five cans daily". c. There was no documentation in the patient's medical record that hospital staff members infused 1000 cc of Peptamen 1.5 through the	A 396	**Individual Responsible:** • Chief Nursing Officer **Date Completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 396	Continued From page 57 patient's feeding tube for 4 of 38 nights between 04/01/17 and 05/08/17. d. There was no documentation in the patient's medical record that hospital staff members offered Boost Plus to the patient for 80/180 cans prescribed between 04/04/17 and 05/08/17. e. On 05/08/17 1:55 PM. the registered nurse (Staff Member #M1) confirmed that documentation in patient's record did not reflect that the patient received 1000 ml of Peptamen 1.5 nightly as ordered; and that the patient had been offered "Boost" nutritional supplement five times daily as ordered. 4. On 05/16/17 at 9:00 AM, Surveyor #7 reviewed the medical record of Patient #K8. A nutrition risk assessment completed on 04/25/17 by a dietician (Staff Member #K1) identified the patient as a moderate nutritional risk with altered nutrition-related laboratory values. A follow-up nutrition consult was ordered because the patient had lost weight as a result of refusing meals during the previous two weeks. The consult (dated 05/10/17) indicated the patient had a weight loss of 16 pounds or 10.8 percent of his/her total body weight within the past month. The patient's current treatment plan (dated 05/09/17) nor the previous treatment plan dated 4/25/2017 identified any treatment plan problems related to nutritional deficiencies. On 5/16/2017 at 2:30 PM, Surveyor #7 had a follow-up interview with a nurse manager (Staff Member #K2). The manager acknowledged that the Patient #K8's treatment plan should have included a problem related to inadequate nutrition.	A 396		

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 396	Continued From page 58 5. On 05/16/17 at 10:00 AM, Surveyor #10 reviewed the medical record of Patient #JW3 and interviewed a registered nurse who provided care in patient's treatment unit (Staff Member #JW9). This record review and interview revealed the following: a. The patient has a history of poor oral intake. On 04/10/17, the patient's physician (Staff Member #JW8) wrote orders for patient care staff members to document the patient's oral intake. On 04/13/17 the physician repeated the order to document oral intake. Based on medical record review, documentation of oral intake was not initiated until 04/18/17. b. An interview with the registered nurse (Staff Member #JW9) confirmed that oral intake had not been documented as ordered 6. On 05/16/17 at 2:30 PM, Surveyor #10 reviewed the medical records of Patient #JW2 and interviewed the Ward Administrator for the patient's treatment unit (Staff #JW6). This record review and interview revealed the following: a. The patient had a long history of refusing to eat. On 03/07/17, the patient underwent a surgical procedure for insertion of a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube surgically inserted through the patient's abdominal wall into the patient's intestine) as an access for supplemental feeding. b. The patient's weights recorded on a monthly vital sign form dated February 2017 through May 2017 indicated the patient weighed 162 lbs. in February 2017 and 147.5 lbs. in May 2017. Documentation on the patient's treatment form dated May 2017 indicated monthly weights were	A 396		

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A 396	Continued From page 59 discontinued on 05/13/17. There was no physician order found to support discontinuance of weights. Item #3- Referrals to Health Care Consultants Based on observation, interview, and record review, the hospital failed to ensure that hospital staff members had an effective system to communicate patient care recommendations made by health care consultants, as demonstrated by Patient #CS12. Failure to consider and implement recommendations made by health care consultants risks patient injury and harm. Findings included: 1. On 05/18/17 at 2:30 PM, Surveyor #8 reviewed a podiatry consult for Patient #CS12, a 54 year old female with a history of diabetes with neuropathy and pain in both feet. The consult dated 05/15/17 noted that the patient had been given new shoes with specific instructions to break in wearing the shoes over the following 1-2 days. The patient was not to wear the shoes continuously until the breaking-in period had been completed. 2. During an interview with Surveyor #8 at the time of the record review, a registered nurse (Staff Member #CS14) reported that the staff had not received the information about when the patient's shoes would arrive. Upon further investigation, the patient reported that she was wearing them. 3. The charge nurse (Staff Member #CS13)	A 396	**Plan of Correction for each specific deficiency cited:** (A 396) #3 The hospital failed to ensure that hospital staff members had an effective system to communicate patient care recommendations made by health care consultants. The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan is part of the interdisciplinary care plan. To ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects recommendations made by health care consultants, the following corrections will be made: • A consultation tracking system was developed to include a tracking spreadsheet for all MD ordered consults, for example, medical nutritional need, physical therapy, and orthotics. **Procedure/Process to implement the Plan of Correction:** • ICSM Bulletin MB 17-07 was issued to clarify the roles of each discipline in the consult process. This includes the physician role to: 1. Order Consults 2. Receive and review completed consultations. Will document review date with initial; 3. Document in a progress note, note acceptance of recommendations or rationale for not implementing recommendations. 4. Any interventions accepted will be added to the treatment plan. **Monitoring and tracking procedures:** • Consultation tracking system was developed to include a tracking	

			spreadsheet for all MD ordered consults e.g., nutritional need (medical), physical therapy, and orthotics. Consult patients will be tracked to ensure that specialty consults have been ordered, scheduled, and reviewed by the physician and treatment plan amended. • Ward Administrators audit the consult tracking spreadsheet on every business day to assure treatment plans have been updated based on consultation recommendations. If deficiencies are identified Ward Administrators notify the appropriate discipline for immediate follow up. Center Directors are notified by Ward Administrators when deficiencies are not corrected. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program.** The Utilization Management (UM) Department will provide audit result regarding timeliness of consultations to the Chief Nursing Officer and Chief Medical Officer. The CNO and CMO will develop recommendations of actions and present to Patient Care Quality Council and Governing Body on a quarterly basis. **Individual Responsible:** • Chief Nursing Officer **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 396	Continued From page 60 interviewed unit staff and reported that the consultative summary and instructions for breaking in the shows had been placed into the patient's attending physician's mailbox by the staff member who had escorted the patient to get her shoes. The nurses had not been informed that the shoes had been received and the process for breaking in the shoes. 4. The registered nurse (Staff Member #CS14) caring for the patient who was wearing the shoes assessed the patient's feet and reported that there was a blister on the right big toe.	A 396		
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS- (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by:	A 405		

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A 405	Continued From page 61 . Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure all hospital staff members followed its procedure for identification of patients prior to medication administration, as demonstrated by 2 of 2 patients observed (Patients #KM14, #KM15). Failure to follow the hospital's patient identification policy places patients at risk of injury or death. Findings included: 1. The hospital policy, "Patient Identifiers Including Photograph" Policy #8.11 (Effective Date: 05/08/17) read: "A. All staff will use at least two patient identifiers when: 1. Administering medications... B. ...Acceptable identifiers include the patient's name, patient's medical record number, telephone number, date of birth, social security number and/or photograph." 2. On 5/17/2017 at 4:10 PM, Surveyor #9 observed medication administration for two patients (Patient #KM14 and patient #KM15). The surveyor observed that the Licensed Practical Nurse (Staff Member #KM7) failed to use two patient identifiers prior to administering their medication for 2 of 2 patients. In both cases, the staff member called the patients by their first name, rather than asking them to state their full name or other identifier per hospital policy. 3. During interview with the Licensed Practical Nurse immediately following the medication administration, the nurse told the surveyor that he knew the policy and should be following the policy.	A 405	**Plan of Correction for each specific deficiency cited:** (A 405) The hospital failed to follow its procedure for identification of patients prior to medication administration. To ensure proper administration of medications the following corrections will be made: • Education will be provided on hospital policy 8.11, “Patient Identifiers” to all licensed staff delivering medication to include the significant risks posed to patients if two patient identifiers are not used. • Organizational Development will provide annual education and competency of the elements of medication administration to all ward based licensed nursing staff; this includes on-call staff. **Procedure/process to implement the Plan of Correction:** • Staff will be trained on updated hospital policy 8.11 “Patient Identifiers.” • Organizational Development will design a training plan to include education of the elements of medication administration, risk taking behavior and impact to patients. • RN3 will complete random medication administration audits and provide immediate education if deficiency is found.	

			Monitoring and tracking procedures: • RN3 will complete random medication administration audits weekly and provide immediate education if deficiency is found. • The RN4 will assess the results of the feedback from the medication administration audit and implement actions as needed to ensure patient safety. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program:** • The Nurse Managers will provide audit results regarding medication administration to the Chief Nursing Officer. The CNO will develop recommendations of actions for any discrepancies and present to Patient Care Quality Council and Governing Body on a quarterly basis. **Individual Responsible:** • Chief Nursing Officer **Date completed:** • October 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 405	Continued From page 62	A 405		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This Standard is not met as evidenced by: Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure health care staff charted in medical records according to hospital charting requirements for 6 of 6 records reviewed (Patients #KM2, #KM6, #KM21, #KM22, #CS2, #CS8). Failure to write accurate, legible, dated and timed medical record entries risks patient harm or injury by misinterpreted information and delay in treatment. Findings included: 1. The hospital's policy and procedure titled "Medical Records Procedures, Charting Requirement" (Policy #1.4, Rev. 3/17) read: "Every Medical Record entry is to be dated and timed , ...the Author identified (signed) and when necessary, authenticated. All record entries must be accurate, complete and legible. ...All incorrect entries will be lined through, initialed, dated and marked "error" ... Do Not Use White Out ..." 2. On 05/24/17 at 9:45 AM, Surveyor #9 reviewed the record for Patient #KM2 and found two consultation reports with illegible initials of staff	A 450	**Plan of Correction for each specific deficiency cited:** (A 450) The hospital failed to ensure staff charted in medical records according to hospital charting requirements. The following corrections will be made: • Goal Oriented Record 1.4 "Medical Records Procedure: Charting Requirements" will be updated to include the requirement that all medical records entries must be legible, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. • Nursing and Physician staff will be educated on the update made to Goal Oriented Record 1.4 "Medical Records Procedure: Charting Requirements", including the requirement to legibly initial, time, and date the consultation reports, non-use of whiteout in the patient's medical record, and the appropriate manner to address errors in the record. **Procedure/process for implementing the plan of correction:** • The approved Goal Oriented Record 1.4 "Medical Records Procedure: Charting Requirements" will be posted to the electronic policy manual for all staff to access and distributed to Executive Leadership and Supervisors. • All staff, including nursing staff and physicians, will receive education via education memorandum on the policy updates and the medical record entry requirements. • HIMS will audit for compliance with legibility, dating, timing and authentication in written or electronic form.	

			Monitoring and tracking procedures to ensure the plan of correction is effective: • 10% of discharge charts monthly will be audited for compliance with legibility, dating, timing and authentication in written or electronic form by HIMS. • Non-compliance will be sent to the supervisor for immediate correction. • Audit results will be tracked, monitored, and reported monthly at the QAPI Committee. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The HIMS Department will provide audit results on legibility, dating, timing and authentication, and non-use of white out and appropriate manner of correcting errors to the Chief Quality Officer (CQO). The CQO will develop recommendations of actions for any discrepancies and present to Patient Care Quality Council and Governing Body on a quarterly basis until 90% compliance is reached for 2 consecutive quarters. **Individual Responsible:** • Chief Quality Officer **Date completed:** • December 31, 2017	

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A 450	Continued From page 63 and without time or date of the acknowledgment of the report. 3. On 05/24/17 at 9:45 AM, Surveyor #9 reviewed the record for Patient #KM22 and found an oncology consultation without the time of initialing practitioner. 4. On 05/24/17 at 11:15 AM, Surveyor #9 reviewed the record for Patient #KM21, and found an imaging report with an illegible initial, without a time or date of initial. A registered nurse working on the patient's unit (Staff Member #KM1) stated the initial could be two different practitioners and was unable to confirm which physician had initialed the form. 5. On 05/24/17 at 11:30 AM, Surveyor #9 reviewed a dietitian consult for Patient #KM6. The consult was without a time of the initialing practitioner. 6. On 05/08/17 at 9:30 AM, Surveyor #8 reviewed the medical record for Patient #CS2 and found that white out had been used on a restraint and seclusion flow sheet dated 04/6/17. A registered nurse working on the patient's unit (Staff Member #CS4) confirmed the finding and stated that hospital policy prohibits use of white-out in a patient record. 7. On 05/09/17 at 11:00 AM, Surveyor #8 reviewed the medical record for Patient #CS8 and found three errors on a seclusion and restraint record dated 04/27/17. The errors had been scribbled over rather than following the hospital policy to line through, write "error" and initial. The physician's order for same event also showed scribbled-over writing. A registered nurse working on the patient's unit (Staff Member #CS6)	A 450		

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A 450	Continued From page 64 confirmed the finding at the time of the observation.			
		A 528		
A 528	482.26 RADIOLOGIC SERVICES- The hospital must maintain, or have available, diagnostic radiological services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications. This Condition is not met as evidenced by: Based on observation, interview, document review, and policy and procedure review, the hospital failed to ensure that radiologic services was properly operated and maintained. Failure to properly operate and maintain radiologic services places staff and patients at risk of injury and patients at risk for inadequate care. Findings included: 1. The hospital failed to ensure the department was supervised by a radiologist.		**Plan of Correction for each specific deficiency cited:** (A 528) #1 The hospital failed to ensure the radiological services were properly operated and maintained. To ensure the hospital provides professionally approved standards for safety and personnel qualifications, the following corrections will be made: • Tacoma Radiology Associates (TRA) contract will be reviewed and updated to increase frequency of supervision by a radiologist. • The Chief Medical Officer will provide oversight of Radiology Services. **Procedure/process for implementing the plan of correction:** • The Chief Medical Officer met with TRA on June 29, 2017 and discussed the supervision needs. The contract update is being drafted.	

			• The Chief Medical Officer will meet with Radiology to outline new organizational structure and supervision chain. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The contract manager will monitor the TRA contract for compliance. • The Chief Medical Officer will provide oversight of Clinical Radiological Services. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Medical Officer will report to Patient Care Quality Council and Governing Body the completion on the update of the TRA contract including supervision. **Individual Responsible:** • Chief Medical Officer **Date completed:** • December 31, 2017	
	2. The hospital failed to update policies and procedures to ensure they comply with current standards of practice.		**Plan of Correction for each specific deficiency cited:** (A528) #2 The hospital failed to ensure updated policies and procedures were completed reflecting current standards. To ensure the hospital provides professionally approved standards for safety and personnel qualifications the following corrections will be made: • WSH Policy 6.16 Radiology Services, Oversight, Safety and Maintenance has been updated to reflect current standards of practice. • TRA reviewed the policy and ensured current standards of practice are reflected. **Procedure/process for implementing the plan of correction:** • TRA provided input to the updated policy 6.16 on June 29, 2017. • The updated policy 6.16 “Radiology Services, Oversight, Safety and Maintenance” will be posted to the hospital’s electronic policy manual for all staff to access as well as sent to supervisors to share with their teams. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • TRA will provide monitoring of policies and procedures to ensure current standards of practice are being met and	

			reflected in policy. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The CMO will provide a report to Patient Care Quality Council on the completion of the updated WSH Policy 6.16 "Radiology Services, Oversight, Safety and Maintenance". **Individual Responsible:** • Chief Medical Officer **Date completed:** • December 31, 2017	
	3. The hospital failed to provide regular staff training for radiology department staff members 4. The hospital failed to conduct staff competency evaluations at regular intervals.		**Plan of Correction for each specific deficiency cited:** (A 528) #3-4 The hospital failed to ensure staff competency evaluations and trainings were conducted at regular intervals. To ensure the hospital provides professionally approved standards for safety and personnel qualifications the following corrections will be made: • The TRA contract will be updated to include regular competency evaluations and trainings by qualified radiology staff. **Procedure/process for implementing the plan of correction:** • The Chief Medical Officer met with the TRA representative to discuss development of competencies and trainings that include regular intervals of evaluation that will be amended in the contract. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • TRA will provide training and monitor staff competency. • The Chief Medical Officer or designee will monitor and track compliance with competency and training. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Medical Officer will provide an annual report to Patient Care Quality Council and Governing Body on the annual completion of Radiology competencies and trainings. **Individual Responsible:** • Chief Medical Officer **Date completed:**	

	5. The hospital failed to ensure shielding equipment is tested at regular intervals.		• December 31, 2017 **Plan of Correction for each specific deficiency cited:** (A 528) #5 The hospital failed to ensure shielding equipment is tested at regular intervals. To ensure the hospital provides professionally approved standards for safety and personnel qualifications the following corrections will be made: • WSH Policy 6.16 "Radiology Services, Oversight, Safety and Maintenance" has been updated to reflect current standard of practice. This policy now reflects intervals for shielding equipment testing. • Shielding equipment will be tested at regular intervals. **Procedure/process for implementing the plan of correction:** • WSH Policy 6.16 "Radiology Services, Oversight, Safety and Maintenance" has been updated to reflect current standards of practice. This policy now reflects intervals for monthly shielding equipment testing. • Results of testing are stored in a binder in the Radiology Office. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • TRA will monitor monthly testing of equipment and storage of test results. Non-compliance will be reported to the Chief Medical Officer. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Medical Officer will provide an annual report to Patient Care Quality Council and Governing Body regarding Radiology equipment testing. **Individual Responsible:** • Chief Medical Officer **Date completed:** • December 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 528	Continued From page 65 Due to the scope and severity of deficiencies cited under 42 CFR 482.26, the Condition of Participation for Radiologic Services was NOT MET. Cross Reference: Tags A0535, A0536, A0546	A 528		
A 535	482.26(b) SAFETY POLICY AND PROCEDURES [§482.26 Condition of Participation: Radiologic Services §. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.] §482.26(b) Standard: Safety for Patients and Personnel The radiologic services, particularly ionizing radiology procedures, must be free from hazards for patients and personnel. This Standard is not met as evidenced by: Item #1 - Policies and Procedures Based on observation, document review, and interview, the hospital failed to ensure that policies and procedures for radiological services were periodically reviewed and revised to reflect current standards of practice. Failure to review policies and procedures regarding radiological services places patients and staff at risk for unsafe care and injury. Findings included:	A 535	See TAG A 528	

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A 535	Continued From page 66 1. On 05/16/17 from 9:15 AM to 10:35 AM, Surveyor #2 inspected the radiology department of the facility. During the inspection, the surveyor asked the imaging technician (Staff Member #TH16) to provide the policy and procedure manuals that guide work in the department. The technician provided policy manuals dated 2004 and a procedure manual titled "VA Decentralized Hospital Computer Program - Radiology" dated 1992. 2. The surveyor asked the technician if there were more current manuals on the hospital computer system. The technician stated that he was unaware if any updated policies or procedures exist. The most recent policy found in the hospital-wide database titled "Radiology Services: Oversight, Safety, and Maintenance" was last updated in 2011. 3. On 05/16/17 from 2:00 PM to 2:30 PM, Surveyor #2 interviewed the Radiology Department Manager (Staff Member #TH12). The manager stated that policies and procedures could not be updated in house because he was not a radiologist. Item #2 - Training and Competency Evaluation Based on policy and procedure review, document review, and interview, the hospital failed to ensure that staff performing ionizing radiology activities received ongoing training and competency evaluations. Failure to regularly train staff and perform competency evaluations places patients at risk for unsafe care and risks staff safety due to unsafe technique.	A 535	See TAG A 528	

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A 535	Continued From page 67 Findings included: 1. The hospital's policy titled, "2.4.14 Radiology Services: Oversight, Safety, and Maintenance" (Rev. 5/2011) read: "Employee Training: The Radiology Supervisor ensures employees who use x-ray equipment receive ongoing training on equipment, safety, and operation." 2. A hospital document titled "Client Service Contract: WSH Radiology Services" (Expiration Date 06/30/17) stated in part, "Special Terms and Conditions: 4. Performance Work Statement. The Contractor shall provide services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below: b. Provide the following professional In-Patient services on a scheduled basis: (3) Provide professional education services for Hospital staff, as determined necessary by either party for providing needed updates and/or changes in radiology ..." 3. On 05/16/17 from 9:15 AM to 10:35 AM, Surveyor #2 inspected the hospital's radiology department. During the inspection, the surveyor asked the imaging technician (Staff Member #TH16) what types of training he receives from the facility regarding radiological services. The technician stated that no training was being conducted. The surveyor also asked how often competency evaluations are being conducted. The technician stated that competency evaluations were not being conducted because there was no other person on staff qualified to perform such evaluations. 4. On 05/16/17 from 2:00 PM to 2:30 PM, Surveyor #2 interviewed the Radiology	A 535		

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A 535	Continued From page 68 Department Manager (Staff Member #TH12). The manager stated that he could not perform competency evaluations or training because he was not a radiologist. 5. The imaging technician (Staff Member #TH16) did not have any radiological services training documented in his clinical education files.	A 535		
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This Standard is not met as evidenced by: Based on observation, policy and procedure review, and interview, the hospital failed to ensure that lead shielding vests were tested to ensure efficacy and safety as required by hospital policy. Failure to ensure shielding equipment is effective and safe risks patient and staff exposure to ionizing radiation. Findings included: 1. The hospital policy titled, "2.4.14 Radiology Services: Oversight, Safety, and Maintenance" (Rev. 5/11) read: "Radiation Protection and Safety: WSH Technologists test the integrity of lead aprons/gonadal-shielding equipment yearly and record and date the testing was completed on a label affixed on the aprons." 2. On 05/16/17 9:15 AM to 10:35 AM, Surveyor #2 inspected the radiology department of the	A 536	See TAG A 528	

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 536	Continued From page 69 facility. The surveyor inspected shielding equipment. One vest was dated 04/12/16, which indicated that this was the last inspection date. 3. At the time of the observation, the surveyor asked the imaging technician (Staff Member #TH16) how often the vests are tested for safety and efficacy. The technician confirmed that the vests should be tested annually and the date of the test written on the vest.	A 536		
A 546	482.26(c), (c)(1) RADIOLOGIST RESPONSIBILITIES §482.26(c) - Standard: Personnel (1) A qualified full-time, part-time or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiologic tests that are determined by the medical staff to require a radiologist's specialized knowledge. For purposes of this section, a radiologist is a doctor of medicine or osteopathy who is qualified by education and experience in radiology. This Standard is not met as evidenced by: Based on interview, policy and procedure review, and document review, the hospital failed to ensure that a radiologist supervised ionizing radiology services. Failure to ensure that a radiologist supervises radiological services places patients at risk for unsafe care and staff members at risk for unsafe working conditions. Findings included: 1. The hospital's policy titled, "2.4.14 Radiology Services: Oversight, Safety, and Maintenance"	A 546	See TAG A 528	

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 546	Continued From page 70 (Rev. 05/11) read: "Radiology Oversight: WSH (Western State Hospital) Radiology Services oversight is provided by a Radiologist credentialed and privileged by the organized Medical Staff." 2. The document titled "Client Service Contract: WSH Radiology Services" (Expiration Date 06/30/17) read: "Special Terms and Conditions: 4. Performance Work Statement. The Contractor shall provide services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below: a. Designate a qualified Radiologist to be director of ionizing radiology services for WSH. (1) The director shall have oversight of the safety of ionizing radiology services to patients and personnel. (2) The director shall review records of equipment maintenance and quality control data semi-annually." 3. On 05/16/17 from 2:00 PM to 2:30 PM, Surveyor #2 interviewed the Radiology Department Manager (Staff Member #TH12). The manager stated that he was assigned a managerial role over the radiology department in 2006 but was not a radiologist. He stated that he was a pathologist and only provides administrative responsibility over the department. He stated that the facility had previously had onsite consultation from the radiological services contractor (Tacoma Radiological Associates) when films were read onsite, but that oversight was reduced when film reading moved offsite. 4. On 05/18/17 at 8:35 AM, Surveyor #2 interviewed the Quality Director (Staff Member #TH13) regarding oversight of the radiology department. She stated that a physician (Staff Member #TH14) and consultant (Staff Member	A 546		

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A 546	Continued From page 71 #TH15) from the radiology contractor came onsite twice a year to evaluate the facility and ensure equipment maintenance was completed. Those individuals did not provide direct oversight of day-to-day operations throughout the year.	A 546		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services; (ii) Is responsible for daily management of the dietary services; and (iii) Is qualified by experience or training. This Standard is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to comply with the food safety requirements of the 2009 Federal Drug Administration Food Code. Failure to implement food safety requirements put patients at risk for development of food borne illness. Findings included: Item #1 - Hand Hygiene 1. The hospital's Food and Nutrition Services Policy 11.10 (effective March 2017), under Procedures A. Handwashing, stated in part; "1. Employees will wash their hands frequently and always in the following situations: ... b. Before gloving and after gloves are removed; ..."	A 620	**Plan of Correction for each specific deficiency cited:** (A 620) #1-4 The hospital failed to implement food safety requirements putting patients at risk for development of food borne illness. To ensure the hospital complies with food safety requirements of the 2009 Federal Drug Administration Food Code the following corrections will be made: • Provide “Just in Time’ training to Dietary Staff regarding: A. (#1) Hand Hygiene standards. B. (#2) Proper sink use for hand hygiene and disposable towel use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 620	Continued From page 72 2. On 05/09/17 between 11:00 AM and 1:10 PM, Surveyor #4 observed lunch service from the service kitchen for Wards S8 and S10. The surveyor observed two Food Service Staff (Staff #RM6 and Staff #RM7) don and doff gloves eleven times without performing a hand wash as required. Reference: 2009 FDA Food Code 2-301.14 (8) Item #2 - Handwashing Sink Available for Use 1. The hospital's 2017 Ward Food Service Worker Handbook; Operational Guidelines for Ward Food Service (dated 1/1/2017), under Hygiene & Handwashing, "What should be provided for washing and drying hands at the hand washing sinks?" (page 22), stated in part, "... a suitable method of hand drying (e.g. paper towels from a dispenser, ...)." The hospital's Food and Nutrition Services Policy 11.10 (effective March 2017), under Procedures A. Handwashing, #2 stated; "Do not wash hands in a pot sink or food preparation sink." 2. On 05/08/17 at 11:20 AM during lunch service for Ward F1, Surveyor #3 observed that a sanitizer bucket was located in the handwashing sink, thereby making the sink inaccessible for handwashing. 3. On 05/09/17 at 11:05 AM, in the service kitchen for Wards S8 and S10, Surveyor #4 observed that there were no disposable towels available within arm's reach of the handwashing sink. The surveyor asked one of the Food Service Staff (Staff Member #RM6) about the empty	A 620	C. (#3) Food Safety including temperatures, sanitation solution, thermometer use. • Update Policy 11.10 “Food and Nutrition Services” to include safe food storage, thermometer use, and temperature verification. • (#4) Equipment Installations: A. Dishwasher drains on E2, E3, E5 work orders submitted and completed B. Ice Machines drains on E8 and Java Center work orders submitted and completed. **Procedure/process for implementing the plan of correction:** • Provide “Just in Time’ training to Dietary Staff regarding: • A. (#1) Hand Hygiene standards. • B. (#2) Proper sink use for hand hygiene and disposable towel use. “Just In Time” training developed for dietary hand hygiene, proper sink use, and Food Safety. • C. (#3) Food Safety including temperatures, sanitation solutions, and thermometer use • Update Policy 11.10 “Food and Nutrition Services” to include safe food storage, thermometer use, and temperature verification. • Assess delivery process of test strips to all units to include Java Site. Implement process improvement as needed. • (#4) Equipment Installations: • Dishwasher drains on E2, E3, E5 work orders submitted and completed • Ice Machines drains on E8 and Java Center work orders submitted and completed. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Director of Dietary or designee will: **Hand Hygiene Item #1-2:** 1. Conduct 10 random observations of hand hygiene weekly in the main kitchen and on the ward kitchens to ensure	

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A 620	Continued From page 73 dispenser. Staff Member #RM6 said, "That's because we don't have a key." 4. On 05/12/17 at 11:30 AM, during lunch service for Wards C2 and C5, Surveyor #2 observed that a sanitizer bucket was located in the handwashing sink. The surveyor asked a Mental Health Technician (Staff Member #TH11) and a Food Service Worker (Staff Member #TH23) why a sanitizer bucket was stored in the handwashing sink when the kitchen also contained a service sink. They stated that the service sink had been turned off earlier in the day for maintenance and had not been turned back on at the time of food service. They acknowledged that the handwashing sink was dedicated for that function and removed the sanitizer bucket. Handwashing sinks must be accessible for handwashing and not used for any other purpose. 5. On 05/16/17 from 2:00 PM to 2:40 PM, Surveyor #4 and the Java Site manager (Staff Member #RM8), toured the Java Site (a coffee service shop for patients). The surveyor observed that the Java Site had been designed and constructed without a handwashing sink as required by state regulation. Staff Member #RM8 said that staff had been performing handwashing in the first compartment (a pot sink) of the three compartment warewashing sink. Staff Member #RM8 acknowledged the observation and stated he would requisition a handwashing sink immediately. Reference: 2009 FDA Food Code 6-301.12; 2009 FDA Food Code 5-205.11 (2); 2009 FDA Food Code 5-230.11 Item #3 - Food Safety	A 620	hand hygiene meets standards and disposable towels are available. 2. Will monitor to a compliance rate of 90% for two consecutive months. **Food Safety Item #3** 1. Audit Cooks Temperature Chart monthly for documented time and temperature. 2. Audit sanitation solutions daily for concentration strength and ensure test strips are available. 3. Observations of 5 meals weekly for proper thermometer use and sanitation. 4. Noncompliance will be analyzed and corrective action will be taken. 5. Audits continue until 100% compliance is met for two consecutive months. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Director of Dietary will present data analysis and recommendations for hand washing, proper use of hand sinks, towels and food safety in the report to Patient Care Quality Council and Governing Body on a quarterly basis until 100% compliance is met for two consecutive months. Patient Care Quality Council will make a decision regarding the recommendations made. **Individual Responsible:** • Director of Dietary Services **Date completed:** • December 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 620	Continued From page 74 1. The hospital's Food and Nutrition Services Policy 11.10 (effective March 2017), under Procedures B. Food Storage, step 6 stated, "Maintain prepared and perishable foods at a safe temperature until served. Use a calibrated thermometer to verify the temperature. Foods shall be maintained at an internal temperature of below 41 degrees Fahrenheit or above 140 degrees Fahrenheit to ensure food safety. The hospital's 2017 Ward Food Service Worker Handbook; Operational Guidelines for Ward Food Service (dated 01/01/17), under Food Serving Procedure (page 53), #7 stated in part, "Use a sanitized calibrated thermometer to monitor the food temperatures..." The 2017 Ward Food Service Workers Handbook; Operation Guidelines for Ward Food Service (dated 01/01/17) under Food Serving Procedure (page 53), #6 stated in part, "...sanitizing solution ... test the solution using test strip ..." 2. On 05/08/17 at 11:20 AM, during lunch service for Ward F1, the Food Service Staff (Staff Member #LM3) and Surveyor #3 used a thin-stemmed thermometer to assess the internal temperature of cooked fish arriving in an enclosed container from the main kitchen. The fish servings had internal temperatures between 119 and 132 degrees Fahrenheit, lower than the minimum hot holding temperature of 135 degrees Fahrenheit required by the food code. Staff Member #LM3 reconditioned the fish servings by reheating to 165 degrees Fahrenheit in a microwave oven.	A 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 620	Continued From page 75 3. On 05/08/17 at 11:20 AM during lunch service for Ward F1, Surveyor #3 observed that the Food Service Staff (Staff Member #LM3) failed to sanitize a thin-stemmed thermometer between uses. 4. On 05/09/17 Surveyor #4 observed two Food Service Staff (Staff Member #RM6 and Staff Member #RM7) prepare food service for Wards S-8 and S-10. At 11:20 AM Staff Member #RM7 removed an analog stem thermometer from a drawer, rinsed it under running water, and dried it with a paper towel before piercing a stack of Reuben sandwiches. At 11:55 AM Staff Member #RM6 rinsed the same analog stem thermometer under running water and dried it with a paper towel before piercing another stack of Reuben sandwiches. Surveyor #4 asked Staff Member #RM6 and Staff Member #RM7 why the thermometer was not sanitized before use. Staff Member #RM6 replied, "I thought it's not good for the food." On 05/10/17 at 11:20 AM, Surveyor #4 observed a Food Service Staff (Staff Member #RM10) prepare food service for Ward S7. Staff Member #RM10 rinsed an analog stem thermometer under running water and dried it with a paper towel prior to inserting the probe into a container of vegetable soup. Surveyor #4 asked Staff Member #RM10 why the thermometer was not sanitized before use. She replied, "I can't put bleach in the food." 5. On 05/09/17 at 1:00 PM in the service kitchen for Wards S8 and S10, and on 05/16/17 at 2:15 PM in the Java Site, Surveyor #4 observed that no sanitizer test strips were available to measure	A 620		

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A 620	Continued From page 76 the concentration of sanitizer solution. A food service staff member (Staff Member #RM7) confirmed that the Ward S8 and S10 service kitchen did not have test strips; and Java Site manager (Staff Member #RM8) confirmed that the Java Site did not have sanitizer test strips. Reference: 2009 FDA Food Code 3-01.16 (1)(a); 2009 FDA Food Code 3-701.11 (1); 2009 FDA Food Code 4-702.11; 2009 FDA Food Code 4-302.14 Item #4 - Equipment Installation 1. The Hobart Operation Manual LX Series manufacturer's directions for use read: "Plumbing Connections: Warning: Plumbing connections must comply with applicable sanitary, safety, and plumbing codes ...Drain: A drain hose is provided with a 3/4" pipe connection adapter. This should be securely plumbed into the sink drain. Use care not to kink the hose. Drain must have a minimum flow capacity of 10 gallons per minute." 2. The Hoshizaki DCM-270BAH ice machine manufacturer instructions for use read, "F. Water Supply and Drain Connections: Drain lines must have a 1/4" fall per foot (2 cm per 1 m) on horizontal runs to get a good flow..." 3. On 05/08/17 between 9:30 AM and 12:30 PM, Surveyor #1 observed that the dishwashers on Wards E2, E3, and E5 had been plumbed such that the drain lines did not slope to prevent water from pooling in the line, thereby allowing for stagnation. 4. On 05/09/17 from 2:00 PM to 3:00 PM, Surveyor #2 toured Ward E8. During the tour, the	A 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 620	Continued From page 77 surveyor inspected a Hoshizaki DCM-270BAH ice machine in the service kitchen. The vinyl drain line had a U-shaped bend before it sloped to the floor drain. The bend in the drain line created a slight loop that could allow water to stagnate and does not follow manufacturer installation instructions. 5. On 05/16/17 at 2:35 PM, Surveyor #4 and the Java Site manager (Staff Member #RM8) observed the drain line from the Hoshizaki Ice Maker in the Java Site. The drain line was nearly horizontal for most of its length (estimated 4-feet) with an area of pooled water; and heavy, black growth. The drain line was not sloped sufficiently to allow it to completely drain to the floor sink where it discharged. Reference: 2009 FDA Food Code 4-204.120; 2009 FDA Food Code 4-501.15	A 620		
A 652	482.30 UTILIZATION REVIEW The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs. This Condition is not met as evidenced by: Based on interview and document review, the hospital failed to implement its utilization review plan for services provided to hospital patients. Failure to develop and implement a plan for review of care provided to patients limits the hospital's ability to improve healthcare services and risks poor patient outcomes.	A 652		

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A 652	Continued From page 78 Findings included: Interviews with quality program and Utilization Management (UM) staff members; and review of the hospital's Utilization Management Plan (Effective October 2015) and quality program data revealed the following: 1. UM managers did not aggregate and submit data regarding the quality of care provided as directed by the hospital's Utilization Management Plan, including medical necessity of admissions, duration of hospital stays, discharge planning, and efficacy of professional services . 2. The Utilization Management Committee did not review professional services as part of the utilization review process. Cross Reference: A0273, A0658	A 652	**Plan of Correction for each specific deficiency cited:** (A 652) #1-2 The hospital failed to implement its Utilization Management (UM) plan for review of services provided to hospital patients. To ensure an effective UM plan the institution must review services furnished by the institution and by members of the medical staff to patients entitled to benefits, the following corrections will be made: • UM will update reports for committee members in order to provide specific data including medical necessity of admissions, duration of hospital stays, discharge planning, and efficacy of professional services. • The Utilization Review (UR) Committee will review the UR Plan and ensure the project plans meet the definition of review of professional services as defined in 42 CFR 482.30(f). • See Tag A 273 • See Tag A 658 **Procedure/process for implementing the plan of correction:** • UM will update the reporting tool to include the following reviews: 1. Medical necessity of admission 2. Duration of hospital stay 3. Discharge planning, barriers to discharge 4. Efficacy of professional services • See Tag A 658 **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Chief Financial Officer will audit, monitor and track monthly UM meeting minutes to ensure medical necessity of admissions, professional services efficacy, duration of hospital stay, discharge planning (barriers to discharge) and efficacy of professional services are being assessed, data collection, action plans implemented and the UM plan for	

A 658	482.30(f) REVIEW OF PROFESSIONAL SERVICES- The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services. This Standard is not met as evidenced by: Based on interview and document review, the hospital failed to review professional services as part of the Utilization Review program. Failure to review professional services limits the hospital's ability to determine if services provided are medically necessary and effective. Findings included:	A 658	services is progressing. **Process improvement: actions incorporated into Quality Assessment and Performance Improvement Program:** • The Chief Financial Officer will include UM audit results, data and actions taken in the quarterly report to Patient Care Quality Council and the Governing Body. **Individual Responsible:** • Chief Financial Officer **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 658	Continued From page 79 1. The hospital's Utilization Management Plan (dated October 2015), under "Utilization Management Procedure Manual, Committee Charter" section "IV. Scope, Duties, and Responsibilities", read: "2. Review data for medical necessity of admissions, active treatment, continued stays, efficacy of professional services, discharge planning and duration of stays. 3. Recommend actions to improve utilization and to monitor the effectiveness and appropriateness of improvement strategies... 5. Review the effectiveness of the UM program annually and revise as appropriate." 2. Under the section titled "II. Scope: Review of Professional Services", the plan showed that the utilization management committee would select the topic of the annual Medical Care Evaluation (MCE) and oversee completion of this evaluation. The plan stated that the purpose of an MCE study was to promote more effective and efficient use of facilities and services, analyze the finding of the study, correct or investigate further any deficiencies or problems, and recommend more effective hospital care procedures. Under the section titled "II. Scope: Functions of the Utilization Management Committee", the plan showed that the committee would review the medical necessity and efficacy of professional services. 3. On 05/17/17 at 3:00 PM, Surveyor #5 interviewed staff members who performed utilization review functions (Staff Members #E8, #E9, #E10, #E11, and #E12) on 05/17/17. The interview revealed that the Utilization Management Committee did not review professional services as part of the utilization	A 658	**Plan of Correction for each specific deficiency cited:** (A 658) The hospital failed to review professional services as part of the Utilization Review (UR) program. To ensure the hospital reviews professional services provided to determine medical necessity and to promote the most efficient use of available health facilities and services the following corrections will be made: • The UR Committee will review and update the committee charter to ensure it includes review of medical necessity and professional services. • The UR Committee will review the UR Plan and ensure the project plans meet the definition of review of professional services as defined in 42 CFR 482.30(f). The plan review will include: 1. UTI Study 2. Physical Therapy evaluations, regarding when the consult is ordered and timeline for completion of the process. • The UR Committee will review and set professional services' projects annually in February each year. • WSH is working with the Federal Contractor (Quality Improvement Organization) for UM to ensure the compliance and health of the UR and management process. **Procedure/process for implementing the plan of correction:** • A UR Committee meeting will be held to: 1. Review the charter and make any relevant updates. 2. Review the UR Plan and 42 CFR 482.30 (f) to ensure the 2017 projects meet the definitions found in the standard. 3. Develop and implement a contract for UM to ensure the compliance and health of the UR program at WSH. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Chief Financial Officer will ensure the	

			charter includes review of medical necessity and professional services and that professional services are included in the UR Plan, that the contract for UR services is initiated and the UM plan for professional services is progressing. • The Chief Financial Officer will audit, monitor and track monthly UM meetings to ensure professional services efficacy per the definition of 42 CFR 482.30 (f) is met and the projects chosen are progressing. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement Program:** • The Chief Financial Officer will include the UM project plan updates quarterly to Patient Care Quality Council and the Governing Body. **Individual Responsible:** • The Chief Financial Officer **Date completed:** • March 31, 2018	

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A 658	Continued From page 80 review process. The hospital's MCE projects implemented in 2015 and 2017 were performance improvement projects involving smoking cessation and antibiotic stewardship and did not meet the definition of review and evaluation of professional services as required by 42 CFR 482.30(f).	A 658		
A 700	482.41 PHYSICAL ENVIRONMENT- The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: Based on observation, interview, record review and review of hospital policies and procedures, the hospital failed to provide a safe and secure environment for patients. Failure to maintain a safe and secure environment risked serious injury or death for patients, staff, and visitors in the hospital. Findings included: The hospital failed to maintain a safe and secure patient care environment that included the following: 1. Systems for ensuring the patient care environment is free from safety hazards, including implementation of a fire watch due to inaccessible exits and inaccessible fire extinguisher cabinets; failure to maintain compliance with NFPA 101-2012 guidelines for fire drills; failure to maintain compliance with	A 700	**Plan of Correction for each specific deficiency cited:** (A 700)The hospital failed to maintain a safe and secure environment, risked serious injury or death for patients, staff, and visitors in the hospital. To ensure the hospital is constructed, arranged and maintained to ensure the safety of patients, and to provide facilities for diagnosis and treatment the following corrections will be made: • See K 354 for Sprinkler Systems out of service which sets the guidelines for initiating a Fire Watch Response. Refer to the details found in K 355 with regard to inaccessible Fire Extinguisher Cabinets. Refer to the details found in K 712 which addresses the guidelines for Fire Drills. Refer to the details found in A 710. • See A 724 • See A 726 • See A 724 • See A 710 **Procedure/process for implementing the plan of correction:** • See A 726 • See A 724 • See A 710 • See K 354 • See K 355 • See K 712 **Monitoring and tracking procedures to**	

			ensure the plan of correction is effective: • See A 726 • See A 724 • See A 710 • See K 354 • See K 355 • See K 712 **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • See A 726 • See A 724 • See A 710 • See K 354 • See K 355 • See K 712 **Individual Responsible:** • Chief Operating Officer **Date Completed:** • November 30, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 700	Continued From page 81 NFPA-25 for the hospital's fire sprinkler system; and failure to maintain compliance with NFPA 72 standards for the hospital's fire alarm system. 2. Systems for ensuring supplies were available, ready to use and not expired. 3. Systems to maintain air pressure relationships within industry standards in appropriate areas. 4. Systems to ensure that items used in the patient environment are maintained in good repair. 5. Systems to ensure the physical facility is maintained for patient safety. Cross Reference: Tags A0710 (Fire/Life Safety Statement of Deficiencies) , A0724, and A0726 Due to the scope and severity of deficiencies identified during the survey, the Condition of Participation for Physical Plant and Environment was NOT MET.	A 700		
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	A 710	See Tag A 700	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 710	Continued From page 82 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to meet the requirements of the 2012 edition of the National Fire Protection Association (NFPA) 101 - Life Safety Code (LSC) and 2012 edition of the NFPA 99 - Health Care Facilities Code (HCFC). Findings included: Refer to the deficiencies written on the ACUTE CARE HOSPITAL MEDICARE LIFE SAFETY inspection report dated 06/01/17 .	A 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 710	Continued From page 83 .	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE- Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: Item #1 - Expired Supplies Based on observation, document review and interview, the hospital failed to ensure that patient care supplies did not exceed their designated expiration dates. Failure to ensure patient care supplies do not exceed their expiration dates risks patient harm due to unsafe and unusable equipment. Findings included: 1. The hospital document titled, "Chapter 8, Nursing Units - Infection Control Policy "(approved by the Infection Control Committee 3/21/2017), under IV. Procedure: D. Medical Supplies: 1. Storage, stated in part, "All Medical supplies shall be checked on at least a monthly basis for outdates ..." 2. On 05/08/17 at 11:45 AM in the F1 exam room, Surveyor #3 identified two containers of "Hibiclens" (a skin antiseptic) with expiration dates of 11/2016 and 02/2017. At the time of the observation, a ward patient safety nurse (Staff Member #LM1) confirmed the finding and discarded the items. 3. On 05/09/17 at 10:20 AM in the F6 environmental cabinet, Surveyor #3 identified 4	A 724	**Plan of Correction for each specific deficiency cited:** (A 724) #1 The hospital failed to ensure patient care supplies do not exceed their expiration dates. Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. To ensure the hospital facilities, supplies and equipment are maintained at an acceptable level of safety and quality the following corrections will be made: • A weekly audit will be conducted by nursing staff on each ward to identify and remove expired equipment and supplies. • A log will be created to track each audit to ensure completion. **Procedure/process for implement the Plan of Correction:** • A weekly audit is conducted by nursing staff on each ward to identify and remove expired equipment and supplies. • A ward based log will be created to track each time an audit was conducted. • Notification was sent to all staff, to include nursing and environmental services, requiring the immediate removal of all Metricide. Any Metricide found was delivered to Central Services for proper disposal. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • A weekly audit conducted by nursing staff on each ward to identify and remove expired equipment and supplies. • Ward Administrator will review the audit weekly for completion and deficiency. • Any deficiency noted will be reported to the Center Director for follow up.	

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A 724	Continued From page 84 bottles of Metricide (a high-level disinfectant). One bottle had an expiration date of 11/2014 and 3 bottles had an expiration date of 01/2015. A staff member removed the bottles at the time of the observation. 4. On 05/10/17 at 2:45 PM, Surveyor #4 identified an expired bottle of Metricide on Ward S8 of the Psychiatric Treatment and Recovery Center (PTRC). The bottle had an expiration date of 01/2015. A staff member removed the bottle at the time of the observation. 5. On 05/11/17 at 11:55 AM, Surveyor #4 identified an expired bottle of Metricide in the Dirty Utility room on Ward S9 of the PTRC. The bottle had an expiration date of 10/2014. The S9 Ward Administrator (Staff RM-1) removed the bottle at the time of the observation. Item #2 - Insect Infestation Based on observation and interview, the hospital failed to maintain shower rooms in a way to prevent infiltration of insects. Failure to prevent insects from entering the patient shower area puts patients at risk from an unsanitary environment. Findings included: On 05/08/17 at 10:10 AM during a tour of the F3 shower room, Surveyor #3 observed small winged insects present in each shower stall. At the time of the observation, the F3 Ward Administrator (Staff Member #LM4) identified the insects as "drain flies", small flies that lay eggs and breed in sludge-based habitats.	A 724	**Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program:** • The results of the weekly audit conducted by nursing staff to identify expired equipment and supplies will be reported to the Center Directors on a monthly basis. • Center Directors will provide a quarterly report on audits, results, data and actions taken to Patient Care Quality Council and Governing Body until 95% compliance is achieved for two consecutive quarters. **Individual Responsible:** • Center Directors **Date completed:** • March 31, 2018 **Plan of Correction for each specific deficiency cited:** (A 724) #2 The hospital failed to maintain shower rooms in a way to prevent infiltration of insects. To ensure the hospital protects patients from unsanitary environments the following corrections will be made: • Custodians will be educated on the proper cleaning techniques for shower stalls. • Custodians will report any unresolved issues regarding drain flies/insects to their immediate supervisor for action. **Procedure/process for implementing the plan of correction:** • Custodian supervisors will provide “Just in Time” training to their direct reports that include: 1. Proper shower cleaning techniques. 2. How to report any concerns with drain flies/insects for immediate action.	

			Monitoring and tracking procedures to ensure the plan of correction is effective: • Custodial Manager will inspect 10% of ward showers monthly to ensure proper cleaning, sanitation and absence of drain flies/insects. • Audit results will be provided to the Deputy Chief Operating Officer monthly. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program:** • The Deputy Chief Operating Officer will include audit of ward showers results, data and actions taken in the report to Patient Care Quality Council and Governing Body on a quarterly basis until 100% compliance is achieved for two consecutive quarters. **Person Responsible:** • Deputy Chief Operating Officer **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 724	Continued From page 85 Item #3 - Damaged Furniture Based on observation and interview, the hospital failed to maintain furniture in the patient care area in a safe and easily cleanable condition. Failure to maintain furniture in a safe and cleanable manner puts patients at risk of injury and infection. Findings included: 1. On 05/08/17 between 9:20 and 10:20 AM during the tour of Ward C8, Surveyor #2 noted pillows stored in the clean utility room. One pillow had visible striated tears on the vinyl surface, making it difficult for staff members to properly clean it. The surveyor found a second torn pillow in the restraint room. The Ward Administrator (Staff Member #TH5) confirmed the findings at the time of the observation, and disposed of the torn pillows. 2. On 05/08/17 at 10:53 AM, Surveyor #2 observed a chair in room C2-352 with an approximately 3 inch diameter tear in the front. At the time of the observation, the Ward Administrator (Staff Member #TH6) confirmed the finding. 3. On 05/08/17 at 3:45 PM, Surveyor #2 toured the treatment mall for the C wards. The surveyor identified torn furnishings in room C9-320. At the time of the observation, the Therapy Supervisor (Staff Member #TH7) confirmed the finding. 4. On 05/10/17 at 9:20 AM, Surveyor #9 observed a chair located in the patient milieu on Ward F1	A 724	**Plan of Correction for each specific deficiency cited:** (A 724) #3 and #4 The hospital failed to maintain furniture, doors and walls in the patient care area in a safe and easily cleanable condition resulting in risk of patient injury and infection. To ensure the hospital, supplies and equipment are maintained at an acceptable level of safety and quality the following corrections will be made: • Infection Prevention Department communicated to all staff regarding the proper removal and disposal of torn pillows. • Ward Administrators will conduct a weekly Environment of Care rounds, to include assessment of any damaged equipment, doors or walls on each ward. **Procedure/Process to implement the Plan of Correction:** • Infection Prevention Department communicated to all staff regarding the proper removal and disposal of torn pillows. • Ward Administrators will conduct a weekly Environment of Care rounds, to include assessment of any damaged equipment, walls or doors on each ward. • Each deficiency will be corrected, to include the removal of damaged furniture and equipment, including torn pillows, submission of work orders for damaged walls or doors. • The findings and follow up actions will be reported to the Center Director on a monthly basis for any further action needed.	

			Monitoring and tracking procedures: • Center Director will review the monthly report of deficiencies and actions. Center Directors will ensure the removal of torn, damaged furniture and work orders are completed for damaged doors and walls. • If results of reviews determine that there are delays in removing items it will be reported to the Chief Operating Officer for action. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program:** • The Chief Operating Officer will include results of ward-based environment of care audits to Patient Care Quality Council and governing Body on a quarterly basis until 95% compliance is achieved for two consecutive quarters. **Individual Responsible:** • Chief Operating Officer **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 724	Continued From page 86 with torn and missing fabric on both arms. The hard plastic structure and the foam cushioning were exposed. The chair was not cleanable. Staff Member #KM5 confirmed these findings at the time of the observations. 5. On 05/10/17 at 2:15 PM , Surveyor #9 observed a chair located in the nursing station on Ward F6 with cracked and missing fabric on both arms exposing the foam. The arms of the chairs were taped over with clear tape, the internal foam could be visualized through the clear tape 6. On 05/10/17 at 4:00 PM, Surveyor #9 observed a cloth chair located in the medication room of Ward F6 with torn fabric on both arms. The foam cushioning was exposed through the torn fabric. The cloth fabric of the chair seat and back were noted to be dirty. The cloth fabric was not cleanable. Staff Member #KM6 confirmed these findings at the time of the observation. Item #4 - Damaged Door and Walls Based on observation and interview, the hospital failed to maintain the physical facility of the hospital to ensure patient safety. Failure to maintain the physical facilities of the hospital puts patients at risk from injury due to environmental hazards. Findings included: 1. On 05/08/17 between 2:00 and 2:20 PM in the Habilitative Mental Health Unit, Surveyor #4 observed peeling paint on the walls in a patient room on Ward W1N and on the walls in a patient room on Ward W1S. At the time of the	A 724		

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 724	Continued From page 87 observations, the day shift manager (Staff Member #RM5) acknowledged the findings. 2. On 05/10/17 at 10:40 AM, on Ward S7 of the Psychiatric Treatment and Recovery Center (PTRC), Surveyor #4 observed sharp edges from the strike plate on the door to Patient Room #222 posed risk of injury. A corner of the strike plate was not flush with the edge of the door. The S7 Ward Administrator (Staff Member #RM11) confirmed the finding and the staff completed repairs during the course of the survey. 3. On 05/10/17 at 9:50 AM, on Ward S7 of the Psychiatric Treatment and Recovery Center (PTRC), Surveyor #4 observed peeling paint in the corridor near a restroom (Room #236) and in the TV Room (room #247). At the time of the observations, the S7 Ward Administrator (Staff Member #RM11) acknowledged the findings. 4. On 05/11/17 at 10:45 AM, on Ward S9 of the PTRC, Surveyor #4 observed peeling paint around the interior door frame of patient room #463. At the time of the observation, the S9 Ward Administrator (Staff Member #RM1) acknowledged the finding. Item #5 - Emergency Equipment Maintenance Based on observation, document review, and interview, the hospital failed to ensure that emergency equipment was inventoried and checked according to hospital policy. Failure to ensure emergency equipment is operational and available places patients at risk of inadequate care in emergency situations.	A 724		

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A 724	Continued From page 88 Findings included: 1. The hospital policy titled "Nursing Services Standard Manual: Medical Emergency Equipment. Procedure 245" (Rev. 11/2015) states in part, "Steps: B. Check and record ward emergency equipment daily by completing the emergency equipment checklist to verify availability, proper location, and operating function." 2. On 05/08/17 at 3:45 PM, Surveyor #2 toured the treatment mall for the C wards. The surveyor inspected the emergency equipment cart in the exam room. The surveyor noted that the checklist had not been documented daily as had been observed in other units. 3. At the time of the observation, the surveyor interviewed the therapy supervisor (Staff Member #TH7) regarding checking the emergency equipment. The supervisor stated the equipment is to be checked once per week. 4. After reviewing the hospital policy, the surveyor returned to the treatment mall on 05/15/17 at 11:07 AM to obtain a copy of a document titled, "Emergency Equipment Checklist". According to the document, the emergency equipment was not checked on 7 of 10 days the treatment mall was open between 05/01/17 and 05/12/17.	A 724	**Plan of Correction for each specific deficiency cited:** (A 724) #5 The hospital failed to ensure that emergency equipment was inventoried and checked according to policy, which places patients at risk of inadequate care in emergency situations. The hospital will maintain emergency equipment to ensure the safety of patients in emergency situations the following corrections will be made: • WSH Nursing Standard 245, Medical Emergency Equipment, will be revised so that daily checks are not required when patients/staff are not present. The checks will occur Monday-Friday excluding holidays. • The Chief Nursing Officer will issue a memorandum to educate all staff on the policy revision. **Procedure/process for implementing the Plan of Correction:** • WSH Nursing Standard 245, Medical Emergency Equipment, will be revised so that daily checks are not required when patients/staff are not present. The checks will occur Monday-Friday excluding holidays. • The Chief Nursing Officer will issue a memorandum to educate all staff on the policy revision. **Monitoring and tracking procedures:** • The Emergency Cart logs will be reviewed monthly by the designated RN4 to maintain 100% compliance. • The RN checking the cart will immediately correct any missing supplies or inoperable equipment. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) program:** • The Chief Nursing Officer will include audit results, data and actions taken regarding emergency carts in the report to Patient Care Quality Council and Governing Body on a quarterly basis.	

			Individual Responsible: • Chief Nursing Officer **Date completed:** • March 31, 2018	
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by:	A 726		

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A 726	Continued From page 89 Based on observation and interview, the hospital failed to maintain air pressure relationships consistent with industry standards for ventilation in healthcare facilities. Failure to maintain air pressure relationships according to industry standards puts patients, visitors, and staff at risk of exposure to communicable diseases. References: TSI Healthcare Guidelines and Standards, Table 7-1 Design Parameters from ANSI/ASHRE/ASHE, Standard 170-2008. Centers for Disease Control and Prevention: Guidelines for Environmental Infection Control in Health-Care Facilities (2003), Pg. 212-214, "Table B.2. Ventilation requirements for areas affecting patient care in hospitals and outpatient facilities." Findings included: 1. On 05/08/17 at 10:53 AM, Surveyor #2 tested the ventilation pressure relationship for clean utility room C3-352. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #TH6). 2. On 05/08/17 at 1:30 PM, Surveyor #2 tested the ventilation pressure relationship for clean utility room C2-252. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #TH8).	A 726	**Plan of Correction for each specific deficiency cited:** (A 726)The hospital failed to maintain air pressure relationships according to industry standards. To ensure the hospital maintains air pressure relationships consistent with industry standard for ventilation in healthcare facilities the following corrections will be made: • Work Orders were submitted for the following**:** -Line Item #1: Ventilation pressure relationship for clean utility room C3-352. -Line Item #2: Ventilation pressure relationship for clean utility room C2-252. -Line Item #3: Ventilation pressure relationship for clean linen room 151 on Ward E7. -Line Item #4: Ventilation pressure relationship for the clean linen room on Ward E8. -Line Item #5: Ventilation pressure relationship in a Clean Utility room on Ward S8 of the Psychiatric Treatment and Recovery Center (PTRC). -Line Item #6: Ventilation pressure relationship in a clean linen closet on Ward S7 of the PTRC. -Line Item #7: Ventilation pressure relationship in a Clean Utility room on Ward S3 of the PTRC. -Line Item #8: Ventilation pressure relationship in the Ward S3 Treatment Room (used to store sterile supplies). • Creation of a new preventative maintenance cycle in the automated maintenance system to test and inspect pressure relationships semi-annually in all clean and dirty utility rooms. **Procedure/process for implementing the plan of correction:** • Generate work order for initial assessment and repair. • Maintenance Trades assess pressure relationships, repair or rebalance air systems as necessary.	

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A 726	Continued From page 90 3. On 05/09/17 at 1:25 PM, Surveyor #2 tested the ventilation pressure relationship for clean linen room 151 on Ward E7. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #TH9). 4. On 05/09/17 at 2:00 PM, Surveyor #2 tested the ventilation pressure relationship for the clean linen room on Ward E8. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #TH10). 5. On 05/09/17 at 3:45 PM, Surveyor #4 tested the ventilation pressure relationship in a Clean Utility room on Ward S8 of the Psychiatric Treatment and Recovery Center (PTRC). The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #RM14). 6. On 05/10/17 at 10:20 AM, Surveyor #4 tested the ventilation pressure relationship in a clean linen closet on Ward S7 of the PTRC. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #RM11). 7. On 05/10/17 at 1:55 PM, Surveyor #4 tested the ventilation pressure relationship in a Clean Utility room on Ward S3 of the PTRC. The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #RM12) and the ward RN3 (Staff	A 726	• Maintenance Supervisor 3 to verify completion of work. • Creation of new preventative maintenance cycle. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Monitoring will occur on a semi-annual basis through the reoccurring preventative maintenance cycle. • Results and corrections will be recorded on the semi-annual inspection • Maintenance Supervisor 3 will review preventative maintenance work orders to ensure follow up work was recorded, and any further action was completed. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Maintenance Facilities Manager will add to the maintenance dashboard A726 status and report actions taken on the dashboard to the Chief Operating Officer monthly until all areas have been assessed and deficiencies corrected. • The Maintenance Facility Manager will report completion of the preventative Maintenance work order cycle creation and pressure relationship air balancing to Patient Care Quality Council. **Individual Responsible:** • Chief Operating Officer **Date completed:** • January 15, 2018	

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

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A 726	Continued From page 91 Member #RM13). 8. On 05/10/17 at 2:10 PM, Surveyor #4 tested the ventilation pressure relationship in the Ward S3 Treatment Room (used to store sterile supplies). The room was under negative air pressure instead of positive pressure with respect to the corridor. This finding was confirmed by the Ward Administrator (Staff Member #RM12) and the ward RN3 (Staff Member #RM13).	A 726		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 - N95 Respirator Fit Testing Program Based on interview and review of hospital policies and procedures, the hospital failed to implement its N95 respirator fit testing program. Failure to test for proper fit of N95 respirators risks transmission of airborne diseases to patient care staff members. Reference: 29 CFR 1910.134 - "Occupational Health and Safety Standards - Personal Protective Equipment - Respiratory Protection." Findings included: 1. The hospital's policy and procedure titled "Employee N95 Respirator Fit Testing" (Policy No.	A 749	**Plan of Correction for each specific deficiency cited:** (A 749) #1 The hospital failed to implement its N95 respirator fit testing program. To ensure the hospital provides a system for identifying, reporting, investigating and controlling infections and communicable disease of patients and personnel the following corrections will be made: • Replace existing WSH Policy 6.09 Employee N95 Respirator Fit Testing with: Powered Air Purifying Respirators (PAPR). • Develop competency for training related to respirator masks. • Train Infection Control/Employee Health (IC/EH) and Medical Nurse Consultant (MNC) staff as train-the-trainers for “just-in-time” training of appropriate staff as needed. **Procedure/process for implementing the plan of correction:** • Replace existing WSH Policy 6.09 Employee N95 Respirator Fit Testing with: Powered Air Purifying Respirators (PAPR). • Post new policy 6.08 Powered Air	

			• Purifying Respirators to the hospital's electronic policy manual for all staff access.
			• Develop competency for training related to respirator masks.
			• Train Infection Control/Employee Health (IC/EH) and Medical Nurse Consultant (MNC) staff as train-the-trainers for just-in-time training of appropriate staff as needed:
			  o All current IC/EH and MNC to complete training.
			  o PAPR training is to be part of MNC and IC/EH departmental new-employee. training/competency
			  o PAPR training to be completed annually.
			
			Monitoring and tracking procedures to ensure the plan of correction is effective:
			• The Infection Control Director will track training completion of IC/EH and MNC staff via excel spreadsheet.
			• Director of Infection Control will review quarterly to validate the inclusion of PAPR competencies for all IC/EH and MNC employees new to those departments. Quarterly reviews will continue for one full year.
			
			Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:
			• The Infection Control Director will include Powered Air Purifying Respirator audit results, data and actions taken in the report to Patient Care Quality Council and the Governing Body quarterly for four consecutive quarters and annually thereafter.
			
			Individual Responsible:
			• Infection Control Director
			
			Date completed:
			• March 31, 2018	

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A 749	Continued From page 92 2.4.16; Effective 11/15/15) under "Policy", read: "In the event of potential exposure to airborne pathogenic particles, the Medical Nurse Consultants will don the N95 respirator and ensure the appropriate precautions are applied to the potential host (patient with respiratory communicable disease). If there is concern for potential exposure to staff while implementing precautions, the Medical Nurse Consultant will fit test all necessary staff while implementing precautions using the N95 respirator." Under "Procedure", the policy read : "The Industrial Hygienist will oversee a Train the Trainer (TTT) program to enable the hospital to have the capability to fit test employees with an N95 respirator". 2. On 05/10/17 at 4:00 PM, Surveyor #6 interviewed the hospital's infection preventionist (Staff Member #M3), regarding the hospital's respiratory protection program. During the interview, the staff member stated that not all the Medical Nurse Consultants (MCN) had been fit tested for N95 masks. There was no method for ensuring that an MCN who had been fit tested for an N95 mask was on duty at all times. The staff member also stated that the hospital did not have an industrial hygienist on staff to oversee the TTT program as stated in the policy and procedure. Item # 2 - Hand Hygiene Based on observation and document review, the hospital failed to ensure that staff members complied with the hospital's hand hygiene policy. Failure to perform appropriate hand hygiene puts patients, staff and visitors at risk of infections.	A 749		

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A 749	Continued From page 93 Findings included: 1. The hospital policy titled "Hand Hygiene Guidelines" (Approved 11/15) stated in part, "Policy: If hands are not visibly soiled, use a hospital approved alcohol-based hand rub for routinely decontaminating hands in the following situations: After removing gloves. If there has been any contact with the patient or patient's environment, hands should be decontaminated when leaving the patient's bedside or room." 2. On 05/08/17 between 11:25 and 11:46 AM, Surveyor #9 observed a Licensed Practical Nurse (Staff Member #KM4) prepare and administer oral medications to six patients (Patient #KM6, Patient #KM7, Patient #KM8, Patient #KM9, Patient #KM10, and Patient #KM11). On 6 of 6 occasions the nurse failed to perform hand hygiene prior to donning gloves and administering medication. 3. On 05/09/17 from 9:00 to 9:45 AM, Surveyor #2 observed a housekeeping procedure on Ward C2. The housekeeper (Staff Member #TH1) did not conduct hand hygiene following glove changes on five separate occasions. 4. On 05/09/17 from 11:00 to 11:40 AM, Surveyor #2 observed a housekeeping procedure on the treatment mall of the C wards. The housekeeper (Staff Member #TH2) cleaned 4 bathrooms and the high touch surfaces of approximately 20 rooms without changing gloves or performing hand hygiene. The housekeeper did not change gloves following cleaning of bathrooms before moving to cleaning the high touch surfaces of classrooms. 5. On 05/09/17 at 2:00 PM, Surveyor #2 observed	A 749	**Plan of Correction for each specific deficiency cited:** (A 749) #2 The hospital failed to ensure staff members complied with the hospital's hand hygiene policy. To ensure a system for identifying, reporting, investigating and controlling infections the following corrections will be made: • Organizational Development, in consultation with the Infection Control Department will create and implement training on Hand Hygiene for Medication Administration. • The Infection Control Department will create and implement hand hygiene training for the Environmental Management Services that focuses on the five moments of hand hygiene as defined by the World Health Organization, and hand hygiene before and after gloving. • Annual refresher Hand Hygiene training will be provided to Environmental Management Services. • The Infection Control Director will develop a Hand Hygiene Compliance audit tool to monitor and enforce compliance of Environmental Management Services' hand hygiene practices. **Procedure/process for implementing the plan of correction:** • Organizational Development, in consultation with the Infection Control Department will create and implement training on Hand Hygiene for Medication Administration. • The Infection Control Department will create and implement hand hygiene training for the Environmental Management Services that focuses on the five moments of hand hygiene as defined by the World Health Organization, and hand hygiene before and after gloving. • Annual refresher Hand Hygiene training	

			will be provided to Environmental Management Services. • The Infection Control Director will develop a Hand Hygiene Compliance audit tool to monitor and enforce compliance of Environmental Management Services' hand hygiene practices. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Hand hygiene compliance will be monitored monthly to include the five moments of hand hygiene and before and after gloving; hand hygiene audit results will be disseminated with the expectation of 80 percent or greater compliance; if less than 80 percent, additional training will occur. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement Program:** • Infection Control Director will include evaluation audit results, data and actions taken in the report to Patient Care Quality Council and the Governing Body quarterly. **Individual responsible:** • Infection Control Director **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 749	Continued From page 94 cleaning procedures on E8. The housekeeper (Staff Member #TH3) did not perform hand hygiene during glove changes. 6. On 05/10/17 at 8:50 AM, Surveyor #4 observed a housekeeper (Staff Member #RM9) as he performed a daily room cleaning of Patient Room #275 on Ward S7 of the Psychiatric Treatment and Recovery Center (PTRC). Staff Member #RM9 changed gloves two times without performing hand hygiene as required by policy. 7. On 05/10/17 from 8:52 AM to 9:52 AM, Surveyor #2 observed the cleaning procedure for five patient rooms on C2. The housekeepers (Staff Member #TH1 and #TH4) did not perform hand hygiene during glove changes as required by policy. Hand sanitizer was not present on the cleaning cart. Item # 3 - Medical Instruments Based on observation and document review, the hospital failed to ensure that staff members complied with the hospital policy on handling of procedure instruments in the examination rooms Failure to promptly clean procedural instruments after use, risks inadequate disinfection and sterilization. Findings included: 1. The hospital policy titled "Treatment of Used Medical Instruments on the Wards at WSH" (Effective 07/11/16) stated in part, "Take the instrument return bucket with dirty instruments in it to its location assigned to your ward for sharps collection. Place the instrument return bucket into	A 749	**Plan of Correction for each specific deficiency cited:** (A 749) #3The hospital failed to ensure staff members complied with the policy of cleaning procedural instruments in the treatment rooms. To ensure proper cleaning of procedural instruments in the treatment rooms the following corrections will be made: • WSH will develop a policy that includes clear guidelines for cleaning and storage of procedural instruments. • Organization Development will train staff who work with procedural instruments on the newly created hospital policy, to include timeframes and procedure for cleaning of procedural instruments. **Procedure/process for implementing the plan of correction:** • WSH will develop a policy that includes clear guidelines for cleaning and storage of procedural instruments. • Organization Development will train staff who work with procedural instruments on the newly created hospital policy, to include timeframes	

			and procedure for cleaning of procedural instruments. **Monitoring and tracking procedures to ensure the plan of correction is effective**: Item #3: Medical Instruments • Infection Control Department will conduct random monthly audits of 30% of treatment/dirty utility rooms to ensure procedural instruments are properly transported to central services. • Will monitor until 90% compliance is achieved for two consecutive quarters. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement Program:** • Infection Control Department will report findings to the Infection Control Committee and quarterly to the Patient Care Quality Council. **Individual responsible**: • Infection Control Director **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 749	Continued From page 95 the secondary sharps collection totes found on the pallets in the sharps collection room. Call Central Service at 756-2508 to request a pickup of used instrument for reprocessing. Instruments should be sent to Central Service during the same shift if at all possible to avoid drying of debris on instrumentation." 2. On 05/08/17 at 9:45 AM, Surveyor #3 interviewed a patient safety nurse (Staff Member #LM2) about the process for ensuring prompt removal of bioburden on medical instruments used in the F2 exam room, after observing instruments left in their biohazard container. The nurse indicated that providers are responsible for pre-treating the instruments and putting them in their biohazard container. The nurse indicated that the staff removed the items from the room "every day to a day and a half". 3. On 05/08/17 at 1:45 PM, Surveyor #4 observed contaminated items (bandage scissors and suture scissors) in a covered, plastic container located in the Treatment Room of Ward W1N in the Habilitative Mental Health Unit (HMH). The surveyor asked the ward Day Shift Manager (Staff Member #RM5) about the process for transport of the contaminated items. Staff Member #RM5 said he did not know the process or whether there was a policy. 4. On 05/11/17 at 11:50 AM, Surveyor #4 observed contaminated items (suture scissors and bandage scissors) in a covered, plastic container located in the Dirty Utility room of Ward S9. Item #4 - Environmental Cleaning	A 749	**Plan of Correction for each specific deficiency cited:** (A 749)#4-5 The hospital failed to perform appropriate cleaning of the patient's environment. To ensure a system for identifying, reporting, investigating and controlling infections the following corrections will be made: • Environmental Management Services Supervisors will include on-going infection control training in their staff meeting regarding environmental cleaning and standard protocols for chemical use • Environmental Management Services Supervisors will observe the room cleaning practices of four employees per month. Observations will be documented on a room cleaning audit report. • Environmental Management Services Supervisors will observe the employees cleaning practice and evaluate competencies annually. **Procedure/process for implementing the plan of correction:** Item #4: Environmental Cleaning Item #5: Disinfectant Use • Environmental Management Services Supervisors will include on-going infection control training in their staff meeting regarding environmental cleaning and standard protocols for chemical use. • Environmental Management Services Supervisors will observe the room cleaning practices of four employees per month. Observations will be documented on a room cleaning audit report. • Environmental Management Services Supervisors will observe the employees cleaning practice and evaluate competencies annually.	

			Monitoring and tracking procedures to ensure the plan of correction is effective: • Training compliance will be monitored yearly by the Department Manager. • If a staff member is unable to demonstrate competency they will be retrained and then reassessed for competency. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement Program:** • The Department Manager will report audit findings to the Infection Control Committee who will report to Patient Care Quality Council. **Individual responsible:** • Chief Operating Officer **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 96 Based on observation, and review of hospital policy and procedures, the hospital failed to ensure that staff members followed the hospital's policy for cleaning in the patient's environment. Failure to properly clean the patient's living environment places patients at risk of illness or infection. Findings included: 1. Review of hospital policies and procedures showed the following: a. The hospital's policy and procedure titled, "Environmental Services Standard Operating Procedures" read on page 10, step 9, "Damp dust front and back of door, door knobs, hinges, tops of doors with cleaning cloth dipped in germicidal detergent solution." b. A hospital document titled, Behavioral Health Administration Inter-Hospital Policy, Policy No. 1.7 (Effective Date: 01/30/17), under "Step C. Prepare the seclusion/restraint room, Key Points", read: "On a regular basis (and after use), seclusion/restraint room and mattress are checked and cleaned when room is unattended." c. The hospital's policy titled, "Chapter 8, Nursing Units - Infection Control Policy" (Approved by the Infection Control Committee 03/21/17), under "IV. Procedure, J. Cleanliness and Sanitation, 2. Routine and Terminal Cleaning", read: " ...Thorough cleaning of each patient's room (incl. [including] mattress and pillow) ..." 2. On 05/09/17 at 9:00 AM, Surveyor #1 observed a daily cleaning of patient room #112 on unit E5. During the process, the housekeeper (Staff	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 749	Continued From page 97 Member #A6) cleaned the patient's restroom, but did not disinfect the patient's restroom door or doorknob. 3. On 05/09/17 at 10:25 AM, Surveyor #4 observed a used menstrual pad in the wastebasket of Room #537, the Seclusion Room (#537) on Ward S10 of the Psychiatric Treatment and Recovery Center (PTRC). The surveyor asked the Ward S10 RN3 (Staff Member #RM15) and Staff Member #RM16 about the procedure for cleaning the Seclusion Room between uses. Staff Member #RM15 stated the room was checked before a new patient was admitted. Staff Member #RM16 said the restroom was cleaned daily on a rotation with the ward restrooms. 4. On 05/10/17 at 8:00 AM on Ward S7, Surveyor #4 observed a housekeeper (Staff Member #RM9) as he sprayed disinfectant cleaner onto the top surface of a patient mattress and used a cloth to wipe the top and bottom surfaces of the mattress. The staff member wiped none of the side surfaces with disinfectant. Staff Member #RM9 then used his gloved hand to remove gross debris from the flat surface of the molded-plastic bed. No part of the bed was wiped with disinfectant. The S7 Ward Administrator (Staff Member #RM11) acknowledged the observations. 5. On 05/11/17 at 11:10 AM, Surveyor #4 observed waste wrappers from an adhesive bandage and alcohol swab in the seat of the restraint chair in the Seclusion Room on Ward S9 of the PTRC. The S9 Ward Administrator (Staff Member #RM1) and the S9 Ward Clerk (Staff Member #RM2) acknowledged the observation. Item #5 - Disinfectant Use	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A 749	Continued From page 98 Based on observation and interview, the hospital failed to ensure that housekeepers knew the contact time for disinfectants. Failure to know the contact time for disinfectants prevents staff members from properly using disinfectants and risks infection of patients and staff. Findings included: 1. The manufacturer's instructions for use for Ecolab Disinfectant 2.0 read: "Contact Time: Use a 10-minute contact time for disinfection against all other viruses, fungi, and bacteria claimed." 2. On 05/09/17 from 9:00 to 9:45 AM, Surveyor #2 observed a housekeeper (Staff Member #TH1) clean a common area on ward C2. The surveyor asked the housekeeper for the contact time (the time required to kill microorganisms) of the disinfectant (Ecolab Disinfectant 2.0). The housekeeper stated that the product did not have a contact time. 3. On 05/10/17 at 8:00 AM, Surveyor #4 observed a housekeeper (Staff Member #RM9) on Ward S7 during a daily room cleaning of Patient Room #275. The surveyor observed that the surface of the mattress appeared dry when Staff Member #RM9 exited the room. The housekeeper did not monitor disinfectant cleaner to ensure the surface of the patient mattress remained wet for 10 minutes as directed by the manufacturer instructions for use. Item #6 - Sharps Containers	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 749	Continued From page 99 Based on observation, interview and document review, the hospital failed to ensure that staff members followed the hospital's policy for handling sharps containers (receptacles for needles and other "sharp" items contaminated with potentially infectious materials). Failure to maintain sharps containers in a safe manner puts staff and patients at risk of exposure to infectious organisms. Findings included: 1. The hospital document titled, "Chapter 8, Nursing Units - Infection Control Policy" (approved by the Infection Control Committee 3/21/2017), under IV. Procedure: A. Standard Precautions: 4. "Sharps" Handling, stated in part, " ...Full sharps containers must be sealed and returned to Central Service within 7 days." 2. On 05/11/17, at 11:30 AM, during a tour of Ward S9 of the Psychiatric Treatment and Recovery Center (PTRC) with the Ward Administrator (Staff Member #RM1) and the Ward Clerk (Staff Member #RM2), Surveyor #4 observed a full sharps container on a shelf in the Medication Room. 3. At the time of the observation, Staff Member #RM1 stated the room was not currently being used by staff due to an in-progress HVAC project. The surveyor asked the Ward Administrator and the Ward Clerk about the process for transport of the contaminated items and the sharps container. They stated that they were not sure how long the contaminated items or the sharps container had been awaiting transport. Staff Member #RM2 stated that normally an RN takes a full sharps container immediately to the waste collection	A 749	**Plan of Correction for each specific deficiency cited:** (A 749)#6 The hospital failed to ensure that staff members followed the hospital's policy for handling sharp containers. To ensure that sharp containers are maintained in a safe manner the following corrections will be made: • Will develop a WSH policy regarding clear guidelines for Sharps Container disposal. • After each ward/room move the Ward Administrator will return to the vacated ward/room and conduct a thorough walk-through to ensure all sharps containers were removed. • The Infection Control Director communicated a reminder of Sharps Container disposal on the EBB. **Procedure/process for implementing the plan of correction:** • Develop a WSH policy regarding clear guidelines for Sharps Container disposal. • All staff involved in sharps disposal will be trained on the new policy for sharps container disposal. • After each ward/room move the Ward Administrator will return to the vacated ward/room and conduct a thorough walk-through to ensure all sharps containers are removed. • The Ward Administrator will verify rounds by sending an email to the Center Director, stating that the vacant ward has been rounded and all sharps containers are off the vacated ward/room. If sharps containers found the Ward Administrator will remove the container. • The Infection Control Director communicated a reminder of Sharps Container disposal on the EBB.	

			Monitoring and tracking procedures to ensure the plan of correction is effective: • The Ward Administrator will verify walk-through has been completed by sending an email to the Center Director, stating that the vacant ward/room has been rounded and all sharps containers were removed from the vacated ward. • If a sharps container(s) is found, the Ward Administrator will arrange for removal. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Center Directors will report improperly stored sharps containers and actions taken, during ward/room moves in their quarterly report to Patient Care Quality Council and the Governing Body until 100% compliance is achieved. **Individual responsible:** • Center Directors **Date completed:** • March 31, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A 749	Continued From page 100 point. She did not know its location. .	A 749		
A1123	482.56 REHABILITATION SERVICES If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients. This Condition is not met as evidenced by: Based on observation, interview, document review, and policy and procedure review, the hospital failed to ensure that rehabilitation services were organized and staffed to ensure the health and safety of patients. Failure to organize, staff, and operate the rehabilitative services according to acceptable standards of practice places patients at risk for inadequate or delayed care. Findings included: 1. The hospital failed to organize the scope of services and adequately staff the physical therapy department to ensure patient needs were met.	A1123	**Plan of Correction for each specific deficiency cited:** (A 1123)#1 The hospital failed to ensure that rehabilitation services were organized and staffed to ensure the health and safety of patients. To ensure the hospital provides adequate staff in physical therapy the following corrections will be made: • The Chief Medical Officer will meet with Medical Services Supervisor including Physical Therapy staff and evaluate physical therapy staffing and develop a staffing proposal. • Three full time temporary staff have been added as an interim measure while developing a staffing model. **Procedure/process for implementing the plan of correction:** • The Chief Medical Officer will determine staffing needs with input from the Medical Services Supervisor. • Staffing proposal will be developed and presented to Patient Care Quality Council and Governing Body for	

			approval. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Chief Medical Officer will review data on scope of services and adequate staffing from the Physical Therapy Department. • The Chief Medical Officer will use the data collected to monitor timely provision of services by the Physical Therapy Department. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Medical Officer will determine which quality indicators to measure the quality of patient outcomes for physical therapy. These indicators will be presented to Patient Care Quality Council and the Governing Body on a quarterly basis. **Individual Responsible:** • The Chief Medical Officer **Date completed:** • March 31, 2018	
	2. The hospital failed to employ a director for occupational therapy services.		**Plan of Correction for each specific deficiency cited:** (A 1123)#2 The hospital failed to employ a director for Occupational Therapy Services. The following corrections will be made: • A licensed Occupational Therapy (OT) Services Manager was offered the position (start date 8/1/17) to direct the overall operations of occupational therapy services, ensuring that patients receive OT services that are evidence-based and consistent with industry standards. • The OT Services Manager will provide direct clinical supervision to all occupational therapy staff hospital wide, including contracted OT staff. • This position will ensure that OT staff is following clinical practice guidelines and that all OT staff meet minimum standards of competency for their profession. **Procedure/process for implementing the plan of correction:** • Occupational Therapy Services Manager was offered a position to start 8/1/17. • The OT Services Manager will assess the occupational therapy services needs to determine best placement of OT resources.	

			• Completion of competency assessment for all OT staff using a standardized assessment tool. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • The OT Services Manager will assess OT staff using the Competency Based Performance Tool for OT services (CBPET). A CBPET will completed for each OT staff within 60 days of hire and annually thereafter. • Based on a random review of 3 clients per OT staff, the CBPET will assess the quality of OT services provided, as measured by: 1) Timeliness of completion of OT referral 2) Demonstration of OT service competency 3) Review of OT service interventions in the patient's treatment plan 4) Clinical documentation of OT services **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Occupational Therapy Supervisor will assess and evaluate the current OT programs and provide recommendations to Patient Care Quality Council and Governing Body for approval. Corrective action plans will be developed and implemented as needed if there are gaps in OT services or OT services are not meeting standards. **Individual Responsible:** • Chief Clinical Officer **Date completed:** • March 31, 2018	
	3. The hospital failed to ensure that physical therapy services were ordered before scheduling therapy sessions.		See A 049 #2 for consultation process ensuring orders are written before scheduling of therapy session.	
	4. The hospital failed to ensure physical therapy services were documented in patient medical records.		See A 049 #2 for consultation process ensuring services are documented in the patient medical records.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

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WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A1123	Continued From page 101 5. The hospital failed to ensure staff performed rehabilitative services according to the patient's treatment plan. Due to the scope and severity of deficiencies cited under 42 CFR 482.56, the Condition of Participation for Rehabilitation Services was NOT MET. Cross Reference: Tags A1124, A1125, A1132, A1133, A1134	A1123	See A 049 #2 for consultation process and documentation in the treatment plan. See Tags A 1133, A 1134	
A1124	482.56(a) ORGANIZATION OF REHABILITATION SERVICES The organization of the service must be appropriate to the scope of the services offered. This Standard is not met as evidenced by: . Based on policy and procedure review and interview the hospital failed to ensure that the organization and staffing of physical therapy services was appropriate to the scope of services offered. Failure to adequately organize the scope of services for the physical therapy department and staff it accordingly places patients at risk for inadequate care or delays in receiving necessary treatments. Findings included: 1. On 05/11/17 at 10:25 AM, Surveyors #2 and #6 interviewed the physical therapy manager (Staff Member #TH20) regarding the overall physical therapy structure. The manager stated that the physical therapy department consisted of two physical therapists and one ambulation technician	A1124	See A 1123 #1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1124	Continued From page 102	A1124		

for the 842 bed facility. The department was in the process of hiring a physical therapy assistant. The department offered restorative and preventative therapy services but was only recently able to add skilled therapy with the addition of the second physical therapist (Staff Member #TH22). The manager stated that the department had also been able to increase the treatment frequency for patients with the addition of the new physical therapist.

Surveyor #2 asked the manager to describe how ambulation therapy functions in the hospital. The manager stated that this service was conducted on the unit by the nursing department. The physical therapy department has an ambulation technician located in the department to perform restorative therapy, but the department does not provide on-unit therapy, such as range of motion or ambulation exercises. The manager stated that physical therapy staff is not allowed to conduct therapy on the unit and must rely on the medical escort service to coordinate patient care in the department. The surveyor asked the manager if any training with the nursing staff on physical therapy procedures had been conducted to ensure continuity of care. The manager stated that the last training had occurred at least four years ago.

2. On 05/16/17 from 10:35 AM to 10:55 AM, Surveyor #2 conducted another interview with the physical therapy manager (Staff Member #TH20) regarding patient assessments and staffing. The manager stated that five additional physical therapists had been contracted to conduct patient assessments on 05/15/17. He stated that this staff was necessary to complete 19 additional assessments that had been submitted as a result of survey findings and continue with the standard

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A1124	Continued From page 103 case load. He stated that he was happy that the facility was utilizing its therapy staffing contract because the department was able to receive the help they needed and departmental staff were able to provide better quality of care. 3. On 05/24/17 at 11:30 AM, Surveyor #2 requested a scope of services policy for the physical therapy department to ensure that staffing was adequate to handle the scope of practice being conducted at the facility. No scope of practice document could be provided. The manager provided a document titled "Rehabilitative Services - Inpatient Evaluation - Physical Therapy (WSH 23-170)" (Rev. 12/2012) as the closest example of a document describing what physical therapy staff assesses that might dictate subsequent services. The Quality Director (Staff Member #TH13) coordinated the request for the scope of practice document and confirmed that the only documentation was the policy described above. ,	A1124		
A1125	482.56(a)(1) DIRECTOR OF REHABILITATION SERVICES The director of the services must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services. This Standard is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that an individual directed the overall operations of occupational therapy services. Failure to have a director of occupational therapy with oversight of the entire services places	A1125	See A 1123 #2	

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A1125	Continued From page 104 patients at risk of inadequate care. Findings included: 1. On 05/23/17 from 10:30 AM to 11:00 AM, Surveyor #2 interviewed an occupational therapist (Staff Member #TH17) regarding the hospital's occupational therapy services. The surveyor asked the therapist how the service was organized and if there was a director that provided oversight over the entire service. The therapist stated that occupational therapy is managed on the unit with oversight from the therapy supervisors for each ward. She stated that there was no single director over the entire service and there has never been one in the past. 2. On 05/23/17 from 11:00 AM to 11:20 AM, Surveyor #2 interviewed the therapy supervisor (Staff Member #TH18) for the E wards. The surveyor asked the supervisor how occupational therapy was supervised. The supervisor stated that occupational therapy is managed by therapy supervisors on each ward. The supervisor confirmed that the hospital did not have director for occupational therapy services and stated that the position had been posted on 05/01/17. 3. Review of a job bulletin for the position "DSHS Occupational Therapy Services Manager" showed the position was posted on 05/01/17 with a closing date of 05/15/17.	A1125		
A1132	482.56(b) ORDERS FOR REHABILITATION SERVICES Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State			

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1132	Continued From page 105 law, and who is authorized by the hospital's medical staff to order the services in accordance with hospital policies and procedures and State laws. This Standard is not met as evidenced by: Based on medical record review, policy and procedure review, and interview, the hospital failed to ensure that orders for physical therapy were written prior to scheduling treatment for 1 of 2 patients reviewed (Patient #TH1). Failure to ensure that orders are written by a credentialed physician prior to performing therapeutic services risks patients receiving medical treatment that may not be necessary or in the best interests of their health. Findings included: 1. The hospital's policy titled, "Medical Records Procedures. 6.3. Rehabilitative Services Consultant Referral (WSH 23-59)" (Revised 01/2016) read: "4. Treatment recommendations shall only be implemented upon approval and signature of the attending physician (Inpatient Treatment Plan Addendum WSH 23-172)." 2. The hospital's policy and procedure titled, "Management of the patient at risk for falls" (Revised March 2017) read: "Area of Responsibility D. Physical Therapy Referral if needed, "4. Refer for PT eval if: a. High Fall Risk (Tinetti score 0-19). B. Pt is non-ambulatory upon admit or with change of condition affecting ambulation". Under the heading "F. Interdisciplinary Management Interventions", the policy read: "9. Consult with physical and occupational therapy to plan a program to	A1132	See A 049	

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	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A1132	Continued From page 106 increase patient's endurance and strength." 3. On 05/16/17 at 3:00 PM, Surveyor #5 reviewed the medical record for Patient #TH1. The patient had a Tinetti score of 16, which indicated the patient had a high risk for falls and should receive a physical therapy evaluation. The attending physician ordered a physical therapy consult on 03/01/17. Staff were unable to locate the consult in the patient's medical record. The physical therapy department faxed a record of the consult to staff at the time of the record review. The consult was completed on 03/09/217 and recommended physical therapy. No physician order was signed for physical therapy services. The patient was scheduled to have physical therapy services on 03/15/17, 03/17/17, 03/21/17, and 03/24/17, but the patient refused. 4. A registered nurse (Staff Member #TH19) confirmed the findings above.	A1132		
A1133	482.56(b)(1) DELIVERY OF SERVICES All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at §482.24. This Standard is not met as evidenced by: . Based on record review, policy and procedure review, and interview, the hospital failed to ensure that rehabilitative services were documented in the medical record for 2 of 2 patients reviewed (Patients #TH1, #TH2). Failure to document rehabilitative services in the patient medical record limits the ability of patient	A1133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN STATE HOSPITAL	9601 STEILACOOM BLVD SW TACOMA, WA 98498

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A1133	Continued From page 107 care staff to have a complete picture of the patient's medical history and develop appropriate treatment plans. Findings included: 1. The hospital policy titled, "Medical Records Procedures. 6.3. Rehabilitative Services Consultant Referral (WSH 23-59)" (Rev. 01/2016) read: "3. The credentialed therapist receiving the referral form will complete the appropriate evaluations within seven (7) calendar days of the date received. A complete record of the evaluation(s) will be provided on the appropriate Rehabilitative Services Database form and placed in the Rehab section of the patient's medical record." 2. Surveyor #5 conducted a chart review for Patient #TH2. The attending physician ordered a physical therapy consult on 12/30/2016. Physical therapy staff completed the consult on 1/3/2017, but staff did not place the results of the evaluation in the medical record. Staff assisting with the medical record review confirmed the finding. 3. On 05/16/17 at 3:00 PM, Surveyor #5 reviewed the medical record for Patient #TH1. The patient had a Tinetti score of 16, which indicates they are at high risk for falls and should receive a physical therapy evaluation. The attending physician ordered a physical therapy consult on 03/01/17. During an interview at the time of the record review, a registered nurse (Staff Member #TH19) was unable to locate the results of the consult in the patient's medical record. The physical therapy department faxed a record of the consult to staff at the time of the record review. The consult was completed on 3/9/2017, and the physical therapist had recommended physical therapy for the	A1133	**Plan of Correction for each specific deficiency cited:** (A 1133)The hospital failed to ensure that rehabilitation services were documented in the medical record. To ensure rehabilitative orders and services are documented in the medical record the following corrections will be made: • Results of all rehabilitation services consultations will be documented in the medical record. • All consultative recommendations will be reviewed by the physician and there is an order prior to delivery of services. • See Tag A 049 **Procedure/process for implementing the plan of correction:** • ICSM Management Bulletin 17-07 was issued regarding consultative services such as rehabilitation. This outlines the process to ensure that consultation documents are placed in the medical record. A physician's order will be completed before delivery of services. • WSH Policy 11.16 Medical Services Consultation was created to include information from ICSM Management Bulletin 17-07. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Ward Administrators will monitor and track the consultation log and report outstanding items to Center Directors for action. • RN3's will audit treatment plans to ensure consultative services' recommendations approved by the physician are incorporated into the treatment plan. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Quality Department will audit results, data and actions taken regarding consultation orders and delivery of service, in the report to Patient Care Quality Council and the Governing Body on a quarterly basis until 95% compliance is achieved for four consecutive quarters.	

			Individual Responsible: • Chief Quality Officer **Date completed:** • October 31, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504003	A. BUILDING _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1133	Continued From page 108 patient. No physical therapy had been ordered. 482.56(b)(2) DELIVERY OF SERVICES	A1133		
A1134	The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the requirements of §409.17 of this chapter. This Standard is not met as evidenced by: Based on interview, document review, and policies and procedures, the hospital failed to ensure that alterations to durable medical equipment were completed according to physical therapy recommendations and the patient's treatment plan, as demonstrated by Patient #TH3 Failure to alter durable medical equipment per physical therapy recommendations places patients at risk of having improperly functioning assist devices that could lead to injury or delay in rehabilitation. Findings included: 1. The hospital's procedure titled "Medical Records Procedures - Procedure: Rehabilitative Services Consult Referral (WSH 23-59)" (Rev. 1/2016) read: " ....5. Possible Criteria for Referral: ...E. Physical Therapy deficit in: i. Range of Motion; ii. Muscle Strength; iii. Mobility (Transfers/Ambulation); iv. Neuromuscular or Musculoskeletal conditions." The policy did not contain information regarding wheelchair assessments. 2. On 05/11/17 at 10:25 AM, Surveyors #2 and #6	A1134	**Plan of Correction for each specific deficiency cited:** (A 1134)The hospital failed to ensure that alterations of durable medical equipment were completed according to physical therapy recommendations and the patient's treatment plan. To ensure patients are not put at risk by having improperly functioning assistive devices the following corrections will be made: • WSH Policy 11.16 Medical Services Consultation was issued to outline referral processes to ensure prompt notification when assistive devices need adjustment. • The Physical Therapy Department makes recommendations, the Physician reviews, and makes orders based on recommendations, the RN is responsible to implement orders including notifying the equipment manager. The Medical Equipment Manager is responsible to ensuring recommendations are implemented. • The RN will document implementation of the physician's order. **Procedure/process for implementing the plan of correction:** • WSH Policy 11.16 Medical Services Consultation was issued to outline the referral process to ensure prompt notification when assistive devices need adjustment. • The Physical Therapy Department makes recommendations, the Physician reviews, and makes orders based on recommendations, the RN is responsible to implement orders including notifying the equipment manager. The Medical Equipment Manager is responsible to ensuring recommendations are implemented. • The RN will document implementation of the physician's order.	

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A1134	Continued From page 109 interviewed the Physical Therapy Manager (Staff Member #TH20) about the physical therapy department's scope of service. The manager stated that the physical therapy department oversees patient wheelchair assessments. The manager stated that the hospital's Equipment Manager (Staff Member #M10) provided and maintained pre-fabricated wheelchairs, attachments, and equipment on behalf of the physical therapy department. 3. Surveyor #5 and #10 reviewed documents regarding a wheelchair strap in need of repair for Patient #TH3. The patient was referred to physical therapy for a wheelchair assessment on 05/12/17. Physical therapy conducted the assessment on 05/13/17. The assessment identified a loose strap and recommended that it be fixed. The patient's treatment plan was updated on 05/18/17 to indicate that the patient's wheelchair strap needed repair. A note on 05/24/17 stated that the patient still needed follow up for the strap repair. No information was documented that the Equipment Manager was notified about the strap or that any follow up on the unit occurred. 4. On 05/24/17 at 10:00 AM, Surveyor #5 interviewed the E8 ward administrator (Staff Member #TH10) and reviewed the referral tracking sheet on ward E8. The wheelchair assessment for Patient #TH3 was documented on the spreadsheet. The ward administrator confirmed that she had documented the patient assessment on the tracking spreadsheet. She stated that she did not know if the issue had been resolved.	A1134	**Monitoring and tracking procedures to ensure the plan of correction is effective:** • The Quality Department will audit consultation recommendations monthly and notify Ward Administrator and Charge Nurse of any process variances. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • The Chief Quality Officer will include audit results, data and actions taken from the consultation process and report to Patient Care Quality Council and the Governing Body on a quarterly basis. **Individual Responsible:** • Chief Quality Officer **Date completed:** • June 30, 2018	